

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)

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System codes that, based on our medical policy, are:

- Subject to a medical necessity review,
- Candidates for a Recommended Clinical Review,
- Not a benefit for our members,
- Considered experimental, investigational and unproven, or
- Not on our prior authorization list (with some exceptions based on members' benefit plans) Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025

Utilization Management Process

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

Procedure Code Groups	Procedure Code Group Descript	ion		
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy criteria. Submit Review to avoid post-service review.	for Recommended	Clinical	
	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 Clinic 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-se policy, which is one of our <u>Clinical Payment and Coding Policies</u> .	ervice review. Chec	ck EIU	
Unlisted or Undefined	Procedures/services not specifically defined or classified, may be sub-	ject to contract/clin	ical review.	
Note: Some codes will appear twice	e if Ending Date and Effective Date are within the same quarter period.			
Procedure Code Code Description	Code Group & Description		Ending Date	
Anesthesia for manipulation of the spine or for closed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999	
procedures on the cervical, thoracic or lumbar spine	Submit for Recommended Clinical Review to avoid post-service review.			

797	Anesthesia for intraperitoneal procedures in upper abdomen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	including laparoscopy; gastric restrictive procedure for morbid obesity	Submit for Recommended Clinical Review to avoid post-service review.		
1200	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
1201	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
1950	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
1951	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
1952	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
1954	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
1960	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
1970	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
1980	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
1981	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
1983	Removal with reinsertion, non-biodegradable drug delivery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2007	9/14/2024
5271	implant 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	Submit for Recommended Clinical Review to avoid post-service review. 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
5272	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
5273	Application of skin substitute graft to trunk, arms, legs, total	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
5274	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
5275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999

15276	Application of skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
5277	Application of skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits,	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
5278	Application of skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
5758	Free fascial flap with microvascular anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2010	12/31/2999
	· · ·	Submit for Recommended Clinical Review to avoid post-service review.		
5769	Grafting of autologous soft tissue, other, harvested by direct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2021	12/31/2999
	excision (eg, fat, dermis, fascia)	Submit for Recommended Clinical Review to avoid post-service review.		
5771	Grafting of autologous fat harvested by liposuction technique to	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2021	12/31/2999
	trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Submit for Recommended Clinical Review to avoid post-service review.		
5772	Grafting of autologous fat harvested by liposuction technique to	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2021	12/31/2999
	trunk, breasts, scalp, arms, and/or legs; each additional 50 cc	Submit for Recommended Clinical Review to avoid post-service review.		
	injectate, or part thereof (List separately in addition to code for	'		
	primary procedure)			
5775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5776	Punch graft for hair transplant; more than 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2005	12/31/2999
	rhytids, general keratosis)	Submit for Recommended Clinical Review to avoid post-service review.		
5781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5787	Abrasion; each additional 4 lesions or less (List separately in	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2005	12/31/2999
	addition to code for primary procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
5788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5819	Cervicoplasty	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
5820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5823	Blepharoplasty, upper eyelid; with excessive skin weighting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	down lid	Submit for Recommended Clinical Review to avoid post-service review.		
5824	Rhytidectomy; forehead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	9/14/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
5825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	flap)	Submit for Recommended Clinical Review to avoid post-service review.		
5826	Rhytidectomy; glabellar frown lines	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	9/14/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
5828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5829	Rhytidectomy; superficial musculoaponeurotic system (SMAS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	flap	Submit for Recommended Clinical Review to avoid post-service review.		
5830	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
	lipectomy), abdomen, infraumbilical panniculectomy	Submit for Recommended Clinical Review to avoid post-service review.		
5832	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); thigh	Submit for Recommended Clinical Review to avoid post-service review.		
5833	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); leg	Submit for Recommended Clinical Review to avoid post-service review.		
5834	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy), hip	Submit for Recommended Clinical Review to avoid post-service review.		
5835	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); buttock	Submit for Recommended Clinical Review to avoid post-service review.		
5836	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); arm	Submit for Recommended Clinical Review to avoid post-service review.		
5837	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); forearm or hand	Submit for Recommended Clinical Review to avoid post-service review.		
5838	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); submental fat pad	Submit for Recommended Clinical Review to avoid post-service review.		
5839	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	lipectomy); other area	Submit for Recommended Clinical Review to avoid post-service review.		
5847	Excision, excessive skin and subcutaneous tissue (includes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
	lipectomy), abdomen (eg, abdominoplasty) (includes umbilical	Submit for Recommended Clinical Review to avoid post-service review.		
	transposition and fascial plication) (List separately in addition to	· ·		
	code for primary procedure)			
5876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	·	Submit for Recommended Clinical Review to avoid post-service review.		
5878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
-	,	Submit for Recommended Clinical Review to avoid post-service review.		1

5879	Suction assisted lipectomy; lower extremity	l	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
7106	,	l	1/1/2005	12/31/2999
	technique); less than 10 sq cm	Submit for Recommended Clinical Review to avoid post-service review.		
7107	Destruction of cutaneous vascular proliferative lesions (eg, laser		1/1/1950	12/31/2999
	technique); 10.0 to 50.0 sq cm	Submit for Recommended Clinical Review to avoid post-service review.		
7108	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	technique); over 50.0 sq cm	Submit for Recommended Clinical Review to avoid post-service review.		
7340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
7340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
7360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	,	Submit for Recommended Clinical Review to avoid post-service review.		
7380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
9105	Ablation, cryosurgical, of fibroadenoma, including ultrasound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	guidance, each fibroadenoma	Submit for Recommended Clinical Review to avoid post-service review.	0,2 ,,20 ,2	, 0 ., _ 0 0 0
9300	Mastectomy for gynecomastia		9/1/2020	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	madediting for gyrioddinadia	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2020	12/01/2000
9303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
300	Mastectorry, simple, complete	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
9316	Mastopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	4/14/2024
9310	Mastopexy	l	1/1/1930	4/14/2024
9318	Breast reduction	Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
9310	breast reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	0/13/2023	12/31/2999
2005	Donald commentation with involved	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
9325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	4444050	10/01/0000
9328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9330	Removal of ruptured breast implant, including implant contents	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	(eg, saline, silicone gel)	Submit for Recommended Clinical Review to avoid post-service review.		
9340	Insertion of breast implant on same day of mastectomy (ie,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	immediate)	Submit for Recommended Clinical Review to avoid post-service review.		
9342	Insertion or replacement of breast implant on separate day from	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2005	12/31/2999
	mastectomy	Submit for Recommended Clinical Review to avoid post-service review.		
9350	Nipple/areola reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2017	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9355	Correction of inverted nipples	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9357	Tissue expander placement in breast reconstruction, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2017	12/31/2999
	subsequent expansion(s)	Submit for Recommended Clinical Review to avoid post-service review.		
9370	Revision of peri-implant capsule, breast, including capsulotomy,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
-	capsulorrhaphy, and/or partial capsulectomy	Submit for Recommended Clinical Review to avoid post-service review.		
9371	Peri-implant capsulectomy, breast, complete, including removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	of all intracapsular contents	Submit for Recommended Clinical Review to avoid post-service review.		, 5 ., 2000
9499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2017	12/31/2999
	Tormotou procedure, predat	In Sittoria. I 1000auro/301vioc reviewed against Medical I Olicy Officia.	11/1/201/	12/01/2000

20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuvtren'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
0560	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
0560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0561	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
)561	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
0979	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
0982	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; radiofreguency	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
0983	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
0985	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
0985	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
1032	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
1073	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
1083	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
1120	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
1121	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
122	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
1123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
1244	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
1245	Reconstruction of mandible or maxilla, subperiosteal 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

21246	Reconstruction of mandible or maxilla, subperiosteal implant;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	complete	Submit for Recommended Clinical Review to avoid post-service review.		
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
21249	Reconstruction of mandible or maxilla, endosteal implant (eg,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	blade, cylinder); complete	service review.		
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
20505			44/4/0040	10/01/0000
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	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	or bilateral including fluoroscopic guidance; single level	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	., .,	12/01/2000
00500	Deventor of the discrete for the first of the discrete for the discrete fo		4/4/0000	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	1/1/2023	12/31/2999
		Policy (CPCP).		
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 annulonlasty unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
22021	or bilateral including fluoroscopic guidance; 1 or more additional	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172020	12/01/2000
	levels (List separately in addition to code for primary procedure)			
22586	Arthrodesis, pre-sacral interbody technique, including disc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	space preparation, discectomy, with posterior instrumentation,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	with image guidance, includes bone graft when performed, L5-S1 interspace	Policy (CPCP).		
22586	Arthrodesis, pre-sacral interbody technique, including disc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	space preparation, discectomy, with posterior instrumentation,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	with image guidance, includes bone graft when performed, L5-S1 interspace	Policy (CPCP).		
22836	Anterior thoracic vertebral body tethering, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	thoracoscopy, when performed; up to 7 vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	0/10/2021	12/01/2000
22836	Anterior thoracic vertebral body tethering, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	thoracoscopy, when performed; up to 7 vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding	07 107202 1	12/01/2000
22836	Anterior thoracic vertebral body tethering, including	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
22030	thoracoscopy, when performed; up to 7 vertebral segments	Submit for Recommended Clinical Review to avoid post-service review.	Z/ 13/ZUZ 4	5/14/2024
22837	Anterior thoracic vertebral body tethering, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	thoracoscopy, when performed; 8 or more vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding		12.12.12
22837	Anterior thoracic vertebral body tethering, including	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
22001	thoracoscopy, when performed; 8 or more vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2024	12/3/1/2333
	unoracoscopy, when performed, o or more vertebral segments	Policy (CPCP).		
22837	Anterior thoracic vertebral body tethering, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	thoracoscopy, when performed; 8 or more vertebral segments	Submit for Recommended Clinical Review to avoid post-service review.		

22838	Revision (eg, augmentation, division of tether), replacement, or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	removal of thoracic vertebral body tethering, including thoracoscopy, when performed	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
2838	Revision (eg, augmentation, division of tether), replacement, or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	removal of thoracic vertebral body tethering, including	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	thoracoscopy, when performed	Policy (CPCP).		
2838	Revision (eg, augmentation, division of tether), replacement, or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	removal of thoracic vertebral body tethering, including	Submit for Recommended Clinical Review to avoid post-service review.		
	thoracoscopy, when performed			
22867	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without fusion, including image	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	guidance when performed, with open decompression, lumbar;	Policy (CPCP).		
2002	single level		4/4/0000	10/04/0000
22867	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without fusion, including image	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	guidance when performed, with open decompression, lumbar;	Policy (CPCP).		
22868	single level Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
22000	stabilization/distraction device, without fusion, including image	review. Check EIU policy, which is one of our Clinical Payment and Coding	1/1/2023	12/31/2999
	guidance when performed, with open decompression, lumbar;	Policy (CPCP).		
	second level (List separately in addition to code for primary	i oney (or or).		
	procedure)			
22868	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without fusion, including image	review. Check EIU policy, which is one of our Clinical Payment and Coding	., .,	12/01/2000
	guidance when performed, with open decompression, lumbar;	Policy (CPCP).		
	second level (List separately in addition to code for primary			
	procedure)			
22869	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without open decompression or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fusion, including image guidance when performed, lumbar;	Policy (CPCP).		
	single level			
22869	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without open decompression or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fusion, including image guidance when performed, lumbar;	Policy (CPCP).		
20070	single level		4/4/0000	10/04/0000
22870	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stabilization/distraction device, without open decompression or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fusion, including image guidance when performed, lumbar;	Policy (CPCP).		
	second level (List separately in addition to code for primary procedure)			
22870	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
22070	stabilization/distraction device, without open decompression or	review. Check EIU policy, which is one of our Clinical Payment and Coding	1/1/2023	12/31/2999
	fusion, including image guidance when performed, lumbar;	Policy (CPCP).		
	second level (List separately in addition to code for primary	i oney (or or).		
	procedure)			
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2017	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		.2,52000
24300	Manipulation, elbow, under anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2013	12/31/2999
	, , , ,	Submit for Recommended Clinical Review to avoid post-service review.		

25259	Manipulation, wrist, under anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2013	12/31/2999
26340	Manipulation, finger joint, under anesthesia, each joint	Submit for Recommended Clinical Review to avoid post-service review. 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		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		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)		8/15/2007	12/31/2999
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral		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

29916	Arthroscopy, hip, surgical; with labral repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2017	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0468	Repair of nasal valve collapse with subcutaneous/submucosal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	lateral wall implant(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0468	Repair of nasal valve collapse with subcutaneous/submucosal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	lateral wall implant(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0469	Repair of nasal valve collapse with low energy, temperature-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
3 100	controlled (ie, radiofrequency) subcutaneous/submucosal	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172020	12/01/2000
	remodeling	Policy (CPCP).		
0469	Repair of nasal valve collapse with low energy, temperature-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/4/2022	12/31/2999
J469			1/1/2023	12/31/2999
	controlled (ie, radiofrequency) subcutaneous/submucosal	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	remodeling	Policy (CPCP).	=/4=/0004	10/01/005
1242	Nasal/sinus endoscopy, surgical; with destruction by	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	radiofrequency ablation, posterior nasal nerve	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1242	Nasal/sinus endoscopy, surgical; with destruction by	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	radiofrequency ablation, posterior nasal nerve	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1242	Nasal/sinus endoscopy, surgical; with destruction by	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	radiofrequency ablation, posterior nasal nerve	Submit for Recommended Clinical Review to avoid post-service review.		
1243	Nasal/sinus endoscopy, surgical; with destruction by	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	cryoablation, posterior nasal nerve	review. Check EIU policy, which is one of our Clinical Payment and Coding		1
	oryonalism, positioner masar nerve	Policy (CPCP).		
1243	Nasal/sinus endoscopy, surgical; with destruction by	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
1240	cryoablation, posterior nasal nerve	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2024	12/01/2000
	Cryoabiation, posterior nasar nerve	Policy (CPCP).		
1243	Nasal/sinus endoscopy, surgical; with destruction by	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
1243	137 0 7		2/13/2024	3/14/2024
1017	cryoablation, posterior nasal nerve	Submit for Recommended Clinical Review to avoid post-service review.	44/4/0040	40/04/0000
1647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	when performed; with balloon occlusion, when performed,	Submit for Recommended Clinical Review to avoid post-service review.		
	assessment of air leak, airway sizing, and insertion of bronchial			
	valve(s), initial lobe			
1648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	when performed; with removal of bronchial valve(s), initial lobe	Submit for Recommended Clinical Review to avoid post-service review.		
1649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	when performed; with removal of bronchial valve(s), each	Submit for Recommended Clinical Review to avoid post-service review.		
	additional lobe (List separately in addition to code for primary	· ·		
	procedure)			
1651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	when performed; with balloon occlusion, when performed,	Submit for Recommended Clinical Review to avoid post-service review.		1.2,51,2000
	assessment of air leak, airway sizing, and insertion of bronchial	Cashin for Accommended Chillion Noview to avoid post-solvide leview.		
	valve(s), each additional lobe (List separately in addition to code			
1000	for primary procedure[s])	INDONE DE LA COMPANSIONE	4/4/0040	10/01/0000
1660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	when performed; with bronchial thermoplasty, 1 lobe	Submit for Recommended Clinical Review to avoid post-service review.		1

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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	12/31/2999
02004		· · · · · · · · · · · · · · · · · · ·	1/1/2016	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
	by tumor extension, percutaneous, including imaging guidance			
	when performed, unilateral; cryoablation	MDO'' : D	0/4/0007	10/01/0000
998	Ablation therapy for reduction or eradication of 1 or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2007	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	by tumor extension, percutaneous, including imaging guidance			
	when performed, unilateral; radiofrequency			
211	Insertion or replacement of temporary transvenous dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	chamber pacing electrodes (separate procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
213	Insertion of pacemaker pulse generator only; with existing dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	leads	Submit for Recommended Clinical Review to avoid post-service review.		
225	Insertion of pacing electrode, cardiac venous system, for left	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/15/2006	12/31/2999
	ventricular pacing, at time of insertion of implantable defibrillator	Submit for Recommended Clinical Review to avoid post-service review.		
	or pacemaker pulse generator (eg, for upgrade to dual chamber	· ·		
	system) (List separately in addition to code for primary			
	procedure)			
267	Exclusion of left atrial appendage, open, any method (eg,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
201	excision, isolation via stapling, oversewing, ligation, plication,	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/01/2000
	clip)	oublinit for recommended offinical review to avoid post-service review.		
268	Exclusion of left atrial appendage, open, performed at the time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
200	of other sternotomy or thoracotomy procedure(s), any method		10/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	(eg, excision, isolation via stapling, oversewing, ligation,			
	plication, clip) (List separately in addition to code for primary			
	procedure)			
269	Exclusion of left atrial appendage, thoracoscopic, any method	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
	(eg, excision, isolation via stapling, oversewing, ligation,	Submit for Recommended Clinical Review to avoid post-service review.		
	plication, clip)			
3274	Transcatheter insertion or replacement of permanent leadless	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2019	12/31/2999
	pacemaker, right ventricular, including imaging guidance (eg,	Submit for Recommended Clinical Review to avoid post-service review.		
	fluoroscopy, venous ultrasound, ventriculography, femoral			
	venography) and device evaluation (eg, interrogation or			
	programming), when performed			
276	Insertion of phrenic nerve stimulator system (pulse generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	and stimulating lead[s]), including vessel catheterization, all	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	imaging guidance, and pulse generator initial analysis with	Policy (CPCP).		
	diagnostic mode activation, when performed	i oney (or or).		
276	Insertion of phrenic nerve stimulator system (pulse generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
_, 0	and stimulating lead[s]), including vessel catheterization, all	review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 10,2024	12/01/2000
		· · ·		
	imaging guidance, and pulse generator initial analysis with	Policy (CPCP).		
276	diagnostic mode activation, when performed	MD Critoria: Procedure/consise reviewed against Medical Policy Cuitaria	2/15/2024	5/14/2024
276	Insertion of phrenic nerve stimulator system (pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/ 13/2024	5/14/2024
	and stimulating lead[s]), including vessel catheterization, all	Submit for Recommended Clinical Review to avoid post-service review.		
	imaging guidance, and pulse generator initial analysis with			
	diagnostic mode activation, when performed			
277	Insertion of phrenic nerve stimulator transvenous sensing lead	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	(List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

33277	Insertion of phrenic nerve stimulator transvenous sensing lead	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	(List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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).		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).		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).		12/31/2999
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)		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

33287	Demoval and replacement of phrenic perve etimulator, including	ICII I. Dragadura/garviga net raimburgad by the Dian. Net cubicat to pro comica	E/4E/2024	12/31/2999
33287	Removal and replacement of phrenic nerve stimulator, including	1	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	review. Check EIU policy, which is one of our Clinical Payment and Coding		
33287	and programming, when performed; pulse generator	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	E/4E/2024	10/01/0000
3287	•	· · · · · · · · · · · · · · · · · · ·	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	review. Check EIU policy, which is one of our Clinical Payment and Coding		
3287	and programming, when performed; pulse generator	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
3287	Removal and replacement of phrenic nerve stimulator, including		2/15/2024	5/14/2024
	vessel catheterization, all imaging guidance, and interrogation	Submit for Recommended Clinical Review to avoid post-service review.		
3288	and programming, when performed; pulse generator	FILL Describer and a section between the District Control of the property of t	E/4E/2024	12/31/2999
3288	Removal and replacement of phrenic nerve stimulator, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and programming, when performed; transvenous stimulation or	Policy (CPCP).		
2000	sensing lead(s)	FILL Durandi we/anning wat uning by well by the Diam Nat or high to man anning	E/4E/0004	40/04/0000
3288	Removal and replacement of phrenic nerve stimulator, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and programming, when performed; transvenous stimulation or	Policy (CPCP).		
2000	sensing lead(s)	MD Oritoria - Day and have to send a send and the standard Delice - Oritoria	0/45/0004	E /4 4 /000 4
3288	Removal and replacement of phrenic nerve stimulator, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	vessel catheterization, all imaging guidance, and interrogation	Submit for Recommended Clinical Review to avoid post-service review.		
	and programming, when performed; transvenous stimulation or			
3289	sensing lead(s) Transcatheter implantation of wireless pulmonary artery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
209			1/1/2019	12/31/2999
	pressure sensor for long-term hemodynamic monitoring,	Submit for Recommended Clinical Review to avoid post-service review.		
	including deployment and calibration of the sensor, right heart			
	catheterization, selective pulmonary catheterization, radiological			
	supervision and interpretation, and pulmonary artery			
2004	angiography, when performed	ND Out and a Day and the second as a second as a second as the second as a sec	4/4/0040	40/04/0000
3361	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
2000	prosthetic valve; percutaneous femoral artery approach	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
3362	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
2000	prosthetic valve; open femoral artery approach	Submit for Recommended Clinical Review to avoid post-service review.	44/4/0045	40/04/0000
363	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2015	12/31/2999
2004	prosthetic valve; open axillary artery approach	Submit for Recommended Clinical Review to avoid post-service review.	44/4/0045	40/04/0000
364	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2015	12/31/2999
.005	prosthetic valve; open iliac artery approach	Submit for Recommended Clinical Review to avoid post-service review.	44/4/0045	40/04/0000
3365	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2015	12/31/2999
	prosthetic valve; transaortic approach (eg, median sternotomy,	Submit for Recommended Clinical Review to avoid post-service review.		
2000	mediastinotomy)	NDO:	4/4/0044	40/04/0000
3366	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
2007	prosthetic valve; transapical exposure (eg, left thoracotomy)	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
367	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	prosthetic valve; cardiopulmonary bypass support with	Submit for Recommended Clinical Review to avoid post-service review.		
	percutaneous peripheral arterial and venous cannulation (eg,			
	femoral vessels) (List separately in addition to code for primary			
2222	procedure)	MD Criteria. Decordure (comico residente de secto de Martin de Dalina C. 1.	4/4/0040	40/04/0000
3368	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	prosthetic valve; cardiopulmonary bypass support with open	Submit for Recommended Clinical Review to avoid post-service review.		
	peripheral arterial and venous cannulation (eg, femoral, iliac,			
	axillary vessels) (List separately in addition to code for primary			
	procedure)			

33369	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	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	Submit for Recommended Clinical Review to avoid post-service review.		
22440	procedure)	MD Criteria: Due es deus / semiles mariantes de maine te Madical Balian Criteria	0/45/0040	40/04/0000
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		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	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)	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

36474	Endovenous ablation therapy of incompetent vein, extremity,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	inclusive of all imaging guidance and monitoring, percutaneous,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	mechanochemical; subsequent vein(s) treated in a single	Policy (CPCP).		
	extremity, each through separate access sites (List separately in			
	addition to code for primary procedure)			
6475	Endovenous ablation therapy of incompetent vein, extremity,		8/1/2006	12/31/2999
	inclusive of all imaging guidance and monitoring, percutaneous,	Submit for Recommended Clinical Review to avoid post-service review.		
	radiofrequency; first vein treated			
6476	Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	inclusive of all imaging guidance and monitoring, percutaneous,	Submit for Recommended Clinical Review to avoid post-service review.		
	radiofrequency; subsequent vein(s) treated in a single extremity,			
	each through separate access sites (List separately in addition			
	to code for primary procedure)			
6478	Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	inclusive of all imaging guidance and monitoring, percutaneous,	Submit for Recommended Clinical Review to avoid post-service review.		
	laser; first vein treated			
6479	Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	inclusive of all imaging guidance and monitoring, percutaneous,	Submit for Recommended Clinical Review to avoid post-service review.		
	laser; subsequent vein(s) treated in a single extremity, each			
	through separate access sites (List separately in addition to			
	code for primary procedure)			
6482	Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2019	12/31/2999
	transcatheter delivery of a chemical adhesive (eg,	Submit for Recommended Clinical Review to avoid post-service review.		
	cyanoacrylate) remote from the access site, inclusive of all	'		
	imaging guidance and monitoring, percutaneous; first vein			
	treated			
6483	Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2019	12/31/2999
	transcatheter delivery of a chemical adhesive (eg,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
6522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3836	Percutaneous arteriovenous fistula creation, upper extremity,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	single access of both the peripheral artery and peripheral vein,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including fistula maturation procedures (eg, transluminal balloon			
	angioplasty, coil embolization) when performed, including all	, ,		
	vascular access, imaging guidance and radiologic supervision			
	and interpretation			
6836	Percutaneous arteriovenous fistula creation, upper extremity,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	single access of both the peripheral artery and peripheral vein,	review. Check EIU policy, which is one of our Clinical Payment and Coding		12.1.7.2000
	including fistula maturation procedures (eg, transluminal balloon			
	angioplasty, coil embolization) when performed, including all	1 only (or or).		
	vascular access, imaging guidance and radiologic supervision			
	and interpretation			
	janu interpretation			

36837	Percutaneous arteriovenous fistula creation, upper extremity,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	separate access sites of the peripheral artery and peripheral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	vein, including fistula maturation procedures (eg, transluminal	Policy (CPCP).		
	balloon angioplasty, coil embolization) when performed,			
	including all vascular access, imaging guidance and radiologic			
	supervision and interpretation			
837	Percutaneous arteriovenous fistula creation, upper extremity,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	separate access sites of the peripheral artery and peripheral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	vein, including fistula maturation procedures (eg, transluminal	Policy (CPCP).		
	balloon angioplasty, coil embolization) when performed,			
	including all vascular access, imaging guidance and radiologic			
	supervision and interpretation			
215	Transcatheter placement of intravascular stent(s), cervical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2006	12/31/2999
	carotid artery, open or percutaneous, including angioplasty,	Submit for Recommended Clinical Review to avoid post-service review.		
	when performed, and radiological supervision and interpretation;			
	with distal embolic protection			
216	Transcatheter placement of intravascular stent(s), cervical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	carotid artery, open or percutaneous, including angioplasty,	Submit for Recommended Clinical Review to avoid post-service review.		
	when performed, and radiological supervision and interpretation;			
	without distal embolic protection			
217	Transcatheter placement of intravascular stent(s), intrathoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2014	12/31/2999
	common carotid artery or innominate artery by retrograde	Submit for Recommended Clinical Review to avoid post-service review.		
	treatment, open ipsilateral cervical carotid artery exposure,			
	including angioplasty, when performed, and radiological			
	supervision and interpretation			
'218	Transcatheter placement of intravascular stent(s), intrathoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
	common carotid artery or innominate artery, open or	Submit for Recommended Clinical Review to avoid post-service review.		
	percutaneous antegrade approach, including angioplasty, when			
	performed, and radiological supervision and interpretation			
'241	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping,	Submit for Recommended Clinical Review to avoid post-service review.		
	and imaging guidance necessary to complete the intervention;			
	venous, other than hemorrhage (eg, congenital or acquired			
	venous malformations, venous and capillary hemangiomas,			
	varices, varicoceles)			
7242	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
'243	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping,	Submit for Recommended Clinical Review to avoid post-service review.		
	and imaging guidance necessary to complete the intervention;			
	for tumors, organ ischemia, or infarction			
7244	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping,	Submit for Recommended Clinical Review to avoid post-service review.		
	and imaging guidance necessary to complete the intervention;			
	for arterial or venous hemorrhage or lymphatic extravasation			

37500	Vascular endoscopy, surgical, with ligation of perforator veins,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	subfascial (SEPS)	Submit for Recommended Clinical Review to avoid post-service review.		
37700	Ligation and division of long saphenous vein at saphenofemoral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	junction, or distal interruptions	Submit for Recommended Clinical Review to avoid post-service review.		
37718	Ligation, division, and stripping, short saphenous vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
37722	Ligation, division, and stripping, long (greater) saphenous veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	from saphenofemoral junction to knee or below	Submit for Recommended Clinical Review to avoid post-service review.		
37735	Ligation and division and complete stripping of long or short	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	saphenous veins with radical excision of ulcer and skin graft	Submit for Recommended Clinical Review to avoid post-service review.		
	and/or interruption of communicating veins of lower leg, with			
	excision of deep fascia			
37760	Ligation of perforator veins, subfascial, radical (Linton type),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	including skin graft, when performed, open,1 leg	Submit for Recommended Clinical Review to avoid post-service review.		
7761	Ligation of perforator vein(s), subfascial, open, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2010	12/31/2999
	ultrasound guidance, when performed, 1 leg	Submit for Recommended Clinical Review to avoid post-service review.		
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	incisions	Submit for Recommended Clinical Review to avoid post-service review.		
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	incisions	Submit for Recommended Clinical Review to avoid post-service review.		
37780	Ligation and division of short saphenous vein at	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	saphenopopliteal junction (separate procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
7785	Ligation, division, and/or excision of varicose vein cluster(s), 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2006	12/31/2999
	leg	Submit for Recommended Clinical Review to avoid post-service review.		
7790	Penile venous occlusive procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2007	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
8204	Management of recipient hematopoietic progenitor cell donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	search and cell acquisition	Submit for Recommended Clinical Review to avoid post-service review.		
8205	Blood-derived hematopoietic progenitor cell harvesting for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	transplantation, per collection; allogeneic	Submit for Recommended Clinical Review to avoid post-service review.		
8206	Blood-derived hematopoietic progenitor cell harvesting for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	1/31/2024
	transplantation, per collection; autologous	Submit for Recommended Clinical Review to avoid post-service review.		
8207	Transplant preparation of hematopoietic progenitor cells;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	cryopreservation and storage	Submit for Recommended Clinical Review to avoid post-service review.		
8208	Transplant preparation of hematopoietic progenitor cells;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	thawing of previously frozen harvest, without washing, per donor	Submit for Recommended Clinical Review to avoid post-service review.		
8209	Transplant preparation of hematopoietic progenitor cells;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	thawing of previously frozen harvest, with washing, per donor	Submit for Recommended Clinical Review to avoid post-service review.		
88210	Transplant preparation of hematopoietic progenitor cells;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	specific cell depletion within harvest, T-cell depletion	Submit for Recommended Clinical Review to avoid post-service review.		
8211	Transplant preparation of hematopoietic progenitor cells; tumor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	cell depletion	Submit for Recommended Clinical Review to avoid post-service review.		
8212	Transplant preparation of hematopoietic progenitor cells; red	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	blood cell removal	Submit for Recommended Clinical Review to avoid post-service review.		
8213	Transplant preparation of hematopoietic progenitor cells; platelet	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	depletion	Submit for Recommended Clinical Review to avoid post-service review.		
88214		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	(volume) depletion	Submit for Recommended Clinical Review to avoid post-service review.		
88215	Transplant preparation of hematopoietic progenitor cells; cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
-	concentration in plasma, mononuclear, or buffy coat layer	Submit for Recommended Clinical Review to avoid post-service review.	1	

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88230	Bone marrow harvesting for transplantation; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	1/31/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
8232	Bone marrow harvesting for transplantation; autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
8240	Hematopoietic progenitor cell (HPC); allogeneic transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	per donor	Submit for Recommended Clinical Review to avoid post-service review.		
8241	Hematopoietic progenitor cell (HPC); autologous transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	1/31/2024
	1 1 3 (-7/1 3 1	Submit for Recommended Clinical Review to avoid post-service review.		
8242	Allogeneic lymphocyte infusions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
)_	7 mogeriele lymphocyte imacione	Submit for Recommended Clinical Review to avoid post-service review.	17 17 1000	12/01/2000
3243	Hematopoietic progenitor cell (HPC); HPC boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
3243	l lematopoletic progenitor cell (FIFC), FIFC boost	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
2200			12/1/2014	40/04/0000
3308	Lymphangiotomy or other operations on lymphatic channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2014	12/31/2999
1.100		Submit for Recommended Clinical Review to avoid post-service review.	0/45/0004	40/04/0000
1120	Glossectomy; less than one-half tongue	ı	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1512	Tongue base suspension, permanent suture technique	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1530	Submucosal ablation of the tongue base, radiofrequency, 1 or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	3/31/2024
	more sites, per session	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	'1	Policy (CPCP).		
530	Submucosal ablation of the tongue base, radiofrequency, 1 or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	3/31/2024
	more sites, per session	review. Check EIU policy, which is one of our Clinical Payment and Coding	, .,_0_0	0,0 1,202 1
	more sites, per session	Policy (CPCP).		
1530	Submucosal ablation of the tongue base, radiofrequency, 1 or		4/1/2024	12/31/2999
1000	more sites, per session	Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/01/2000
1872	Gingivoplasty, each quadrant (specify)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2024	12/31/2999
10/2	Gingivopiasty, each quadrant (specify)		2/1/2024	12/31/2999
2440		Submit for Recommended Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
2140	Uvulectomy, excision of uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	uvulopharyngoplasty)	Submit for Recommended Clinical Review to avoid post-service review.		
2950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3206	Esophagoscopy, flexible, transoral; with optical endomicroscopy		9/1/2020	12/31/2999
2200	Looping goodpy, nombio, transoral, with option chaomicioscopy	review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 1,2020	12/01/2000
		Policy (CPCP).		
2210	Esophagogastroduodenoscopy, flexible, transoral; with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2016	12/31/2999
3210			11 13/2010	12/31/2999
	esophagogastric fundoplasty, partial or complete, includes	Submit for Recommended Clinical Review to avoid post-service review.		
	duodenoscopy when performed			
3236			1/1/1950	12/31/2999
	submucosal injection(s), any substance	Submit for Recommended Clinical Review to avoid post-service review.		
3252	Esophagogastroduodenoscopy, flexible, transoral; with optical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
1020Z	endomicroscopy	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	Chaomicroscopy			

43252	Esophagogastroduodenoscopy, flexible, transoral; with optical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	endomicroscopy	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
3257	Esophagogastroduodenoscopy, flexible, transoral; with delivery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2010	12/31/2999
	of thermal energy to the muscle of lower esophageal sphincter	Submit for Recommended Clinical Review to avoid post-service review.		
	and/or gastric cardia, for treatment of gastroesophageal reflux			
	disease			
3284	Laparoscopy, surgical, esophageal sphincter augmentation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2017	12/31/2999
	procedure, placement of sphincter augmentation device (ie,	Submit for Recommended Clinical Review to avoid post-service review.		
	magnetic band), including cruroplasty when performed			
3289	Unlisted laparoscopy procedure, esophagus		6/1/2017	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3290	Esophagogastroduodenoscopy, flexible, transoral; with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	deployment of intragastric bariatric balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3290	Esophagogastroduodenoscopy, flexible, transoral; with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	deployment of intragastric bariatric balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3291	Esophagogastroduodenoscopy, flexible, transoral; with removal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	of intragastric bariatric balloon(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3291	Esophagogastroduodenoscopy, flexible, transoral; with removal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	of intragastric bariatric balloon(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2007	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3644	Laparoscopy, surgical, gastric restrictive procedure; with gastric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Submit for Recommended Clinical Review to avoid post-service review.		
3645	Laparoscopy, surgical, gastric restrictive procedure; with gastric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	bypass and small intestine reconstruction to limit absorption	Submit for Recommended Clinical Review to avoid post-service review.		
		·		
3770	Laparoscopy, surgical, gastric restrictive procedure; placement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	of adjustable gastric restrictive device (eg, gastric band and	Submit for Recommended Clinical Review to avoid post-service review.		
	subcutaneous port components)	·		
3771	Laparoscopy, surgical, gastric restrictive procedure; revision of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	adjustable gastric restrictive device component only	Submit for Recommended Clinical Review to avoid post-service review.		
3772	Laparoscopy, surgical, gastric restrictive procedure; removal of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	adjustable gastric restrictive device component only	Submit for Recommended Clinical Review to avoid post-service review.		
3773	Laparoscopy, surgical, gastric restrictive procedure; removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	and replacement of adjustable gastric restrictive device	Submit for Recommended Clinical Review to avoid post-service review.		
	component only			
3774	Laparoscopy, surgical, gastric restrictive procedure; removal of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	adjustable gastric restrictive device and subcutaneous port	Submit for Recommended Clinical Review to avoid post-service review.		
	components			
3775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2010	12/31/2999
	gastrectomy (ie, sleeve gastrectomy)	Submit for Recommended Clinical Review to avoid post-service review.		

43842	Gastric restrictive procedure, without gastric bypass, for morbid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	12/31/2999
	obesity; vertical-banded gastroplasty	Submit for Recommended Clinical Review to avoid post-service review.		
13843	Gastric restrictive procedure, without gastric bypass, for morbid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	obesity; other than vertical-banded gastroplasty	Submit for Recommended Clinical Review to avoid post-service review.		
13845	Gastric restrictive procedure with partial gastrectomy, pylorus-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2009	12/31/2999
	preserving duodenoileostomy and ileoileostomy (50 to 100 cm	Submit for Recommended Clinical Review to avoid post-service review.		
	common channel) to limit absorption (biliopancreatic diversion	'		
	with duodenal switch)			
43846	Gastric restrictive procedure, with gastric bypass for morbid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	obesity; with short limb (150 cm or less) Roux-en-Y	Submit for Recommended Clinical Review to avoid post-service review.		
	gastroenterostomy	·		
13847	Gastric restrictive procedure, with gastric bypass for morbid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	obesity; with small intestine reconstruction to limit absorption	Submit for Recommended Clinical Review to avoid post-service review.		
43848	Revision, open, of gastric restrictive procedure for morbid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	obesity, other than adjustable gastric restrictive device (separate	Submit for Recommended Clinical Review to avoid post-service review.		
	procedure)			
43886	Gastric restrictive procedure, open; revision of subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	port component only	Submit for Recommended Clinical Review to avoid post-service review.		
13887	Gastric restrictive procedure, open; removal of subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	port component only	Submit for Recommended Clinical Review to avoid post-service review.		
13888	Gastric restrictive procedure, open; removal and replacement of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	subcutaneous port component only	Submit for Recommended Clinical Review to avoid post-service review.		
14705	Preparation of fecal microbiota for instillation, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	assessment of donor specimen	Submit for Recommended Clinical Review to avoid post-service review.		
16707	Repair of anorectal fistula with plug (eg, porcine small intestine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	submucosa [SIS])	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
46707	Repair of anorectal fistula with plug (eg, porcine small intestine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	submucosa [SIS])	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	radiofrequency	Submit for Recommended Clinical Review to avoid post-service review.		
17371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	cryosurgical	Submit for Recommended Clinical Review to avoid post-service review.		
17380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
17382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2008	12/31/2999
	including intraoperative ultrasound guidance and monitoring, if	Submit for Recommended Clinical Review to avoid post-service review.		
	performed			
50360	Renal allotransplantation, implantation of graft; without recipient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2016	12/31/2999
	nephrectomy	Submit for Recommended Clinical Review to avoid post-service review.		
50541	Laparoscopy, surgical; ablation of renal cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
50542	Laparoscopy, surgical; ablation of renal mass lesion(s),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	including intraoperative ultrasound guidance and monitoring,	Submit for Recommended Clinical Review to avoid post-service review.		
	when performed	'		

50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
	radiofrequency	Submit for Recommended Clinical Review to avoid post-service review.		
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	· · · · · · · · · · · · · · · · · · ·	6/1/2008	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
51715	Endoscopic injection of implant material into the submucosal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2007	12/31/2999
	tissues of the urethra and/or bladder neck	Submit for Recommended Clinical Review to avoid post-service review.		
52284	Cystourethroscopy, with mechanical urethral dilation and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	urethral therapeutic drug delivery by drug-coated balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	catheter for urethral stricture or stenosis, male, including	Policy (CPCP).		
	fluoroscopy, when performed			
52284	Cystourethroscopy, with mechanical urethral dilation and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	urethral therapeutic drug delivery by drug-coated balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	catheter for urethral stricture or stenosis, male, including	Policy (CPCP).		
	fluoroscopy, when performed			
52284	Cystourethroscopy, with mechanical urethral dilation and	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	urethral therapeutic drug delivery by drug-coated balloon	Submit for Recommended Clinical Review to avoid post-service review.		
	catheter for urethral stricture or stenosis, male, including	·		
	fluoroscopy, when performed			
52327	Cystourethroscopy (including ureteral catheterization); with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2017	12/31/2999
	subureteric injection of implant material	Submit for Recommended Clinical Review to avoid post-service review.		
52441	Cystourethroscopy, with insertion of permanent adjustable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2015	12/31/2999
	transprostatic implant; single implant	Submit for Recommended Clinical Review to avoid post-service review.		1, 0.1,
52442	Cystourethroscopy, with insertion of permanent adjustable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2015	12/31/2999
	transprostatic implant; each additional permanent adjustable	Submit for Recommended Clinical Review to avoid post-service review.	12, 1,2010	12/01/2000
	transprostatic implant (List separately in addition to code for			
	primary procedure)			
53451	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
30 10 1	bilateral insertion, including cystourethroscopy and imaging	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2021	12/01/2000
	quidance	Policy (CPCP).		
53451	Periurethral transperineal adjustable balloon continence device;		10/1/2024	12/31/2999
30-10 1	bilateral insertion, including cystourethroscopy and imaging	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/01/2000
	quidance	Policy (CPCP).		
53451	Periurethral transperineal adjustable balloon continence device;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	9/30/2024
70-10 1	bilateral insertion, including cystourethroscopy and imaging	Submit for Recommended Clinical Review to avoid post-service review.	3/ 1/2024	3/30/2024
	quidance	Journal for Neconfinenced Clinical Neview to avoid post-service review.		
53452	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
00402	unilateral insertion, including cystourethroscopy and imaging	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/31/2999
	quidance	Policy (CPCP).		
53452	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
33432	unilateral insertion, including cystourethroscopy and imaging	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/31/2999
	quidance	Policy (CPCP).		
53452	Periurethral transperineal adjustable balloon continence device;		5/1/2024	9/30/2024
00402	unilateral insertion, including cystourethroscopy and imaging	Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	3/30/2024
	quidance	Submit for Necommended Clinical Neview to avoid post-service review.		
53453	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
JJ 4 JJ	· · · · · · · · · · · · · · · · · · ·	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/31/2999
	removal, each balloon	Policy (CPCP).		
53453	Porjurathral transparincel adjustable balleen centines as devices	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
00400	Periurethral transperineal adjustable balloon continence device;		10/1/2024	12/31/2999
	removal, each balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

53453	Periurethral transperineal adjustable balloon continence device;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	9/30/2024
	removal, each balloon	Submit for Recommended Clinical Review to avoid post-service review.		
3454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3454	Periurethral transperineal adjustable balloon continence device;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	9/30/2024
	percutaneous adjustment of balloon(s) fluid volume	Submit for Recommended Clinical Review to avoid post-service review.		
3855	Insertion of a temporary prostatic urethral stent, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	urethral measurement	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3855	Insertion of a temporary prostatic urethral stent, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	urethral measurement	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3855	Insertion of a temporary prostatic urethral stent, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2020	5/14/2024
-	urethral measurement	Submit for Recommended Clinical Review to avoid post-service review.		[
3860	Transurethral radiofrequency micro-remodeling of the female	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	bladder neck and proximal urethra for stress urinary	review. Check EIU policy, which is one of our Clinical Payment and Coding	S E0E0	12/31/2000
	incontinence	Policy (CPCP).		
3860	Transurethral radiofrequency micro-remodeling of the female	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
0000	bladder neck and proximal urethra for stress urinary	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 1/2020	12/01/2000
	incontinence	Policy (CPCP).		
4125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
4123	Amputation of penis, complete	Submit for Recommended Clinical Review to avoid post-service review.	3/1/2000	12/31/2999
4200	Injection procedure for Peyronie disease;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/15/2010	12/31/2999
4200	injection procedure for regionic disease,	Submit for Recommended Clinical Review to avoid post-service review.	12/13/2010	12/01/2000
4205	Unjection procedure for Poyronia disease: with surgical exposure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/15/2010	12/31/2999
4203	of plaque	Submit for Recommended Clinical Review to avoid post-service review.	12/13/2010	12/31/2999
4240	Penile plethysmography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
4240	refille pletrysmography	ı	11/1/2019	12/31/2999
4400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
4400	insertion of perille prostriests, non-initiatable (semi-rigid)		1/1/1950	12/31/2999
1101	In a set and a fine collection of the set of	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
4401	Insertion of penile prosthesis; inflatable (self-contained)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
4405	In a set on the second set of the below of the second seco	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
4405	Insertion of multi-component, inflatable penile prosthesis,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
1100	including placement of pump, cylinders, and reservoir	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
4406	Removal of all components of a multi-component, inflatable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
1100	penile prosthesis without replacement of prosthesis	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	10/01/2005
4408	Repair of component(s) of a multi-component, inflatable penile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	prosthesis	Submit for Recommended Clinical Review to avoid post-service review.		
4410	Removal and replacement of all component(s) of a multi-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	component, inflatable penile prosthesis at the same operative	Submit for Recommended Clinical Review to avoid post-service review.		
	session			
4411	Removal and replacement of all components of a multi-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	component inflatable penile prosthesis through an infected field	Submit for Recommended Clinical Review to avoid post-service review.		
	at the same operative session, including irrigation and			
	debridement of infected tissue			I

54415	Removal of non-inflatable (semi-rigid) or inflatable (self-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	contained) penile prosthesis, without replacement of prosthesis	Submit for Recommended Clinical Review to avoid post-service review.		
4416	Removal and replacement of non-inflatable (semi-rigid) or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	inflatable (self-contained) penile prosthesis at the same	Submit for Recommended Clinical Review to avoid post-service review.		
	operative session			
4417	Removal and replacement of non-inflatable (semi-rigid) or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	inflatable (self-contained) penile prosthesis through an infected	Submit for Recommended Clinical Review to avoid post-service review.		
	field at the same operative session, including irrigation and			
	debridement of infected tissue			
4660	Insertion of testicular prosthesis (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		1
5706	Biopsies, prostate, needle, transperineal, stereotactic template	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2013	12/31/2999
0700	guided saturation sampling, including imaging guidance	Submit for Recommended Clinical Review to avoid post-service review.	11/10/2010	12/01/2000
5873	Cryosurgical ablation of the prostate (includes ultrasonic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2007	12/31/2999
3073	guidance and monitoring)	Submit for Recommended Clinical Review to avoid post-service review.	0/13/2007	12/01/2000
5880	Ablation of malignant prostate tissue, transrectal, with high	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2021	12/31/2999
5000	intensity-focused ultrasound (HIFU), including ultrasound	Submit for Recommended Clinical Review to avoid post-service review.	Z1 11ZUZ 1	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E000	guidance	MD Criteria, Presedure/service reviewed against Medical Palian Criteria	11/1/2017	12/31/2999
5899	Unlisted procedure, male genital system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2017	12/31/2999
5070	lutana ay ayunan u mada ta famada	Submit for Recommended Clinical Review to avoid post-service review.	F/4/0000	40/04/0000
5970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
5000		Submit for Recommended Clinical Review to avoid post-service review.	5/4/0000	40/04/0055
5980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
6805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
6810	Perineoplasty, repair of perineum, nonobstetrical (separate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2008	12/31/2999
	procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
7291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
7292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
7296	Revision (including removal) of prosthetic vaginal graft; open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
	abdominal approach	Submit for Recommended Clinical Review to avoid post-service review.		
7335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
7426	Revision (including removal) of prosthetic vaginal graft,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2010	12/31/2999
	laparoscopic approach	Submit for Recommended Clinical Review to avoid post-service review.	1	1 , 2 2 3 3
58321	Artificial insemination; intra-cervical	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		.2.5.,2550
58322	Artificial insemination; intra-uterine		1/1/1950	12/31/2999
USEE	, a anotal incommutation, initia atomio	service review.	1, 1, 1000	12/01/2000
8323	Sperm washing for artificial insemination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
0020	Openin washing for artificial fiscillifiation	service review.	1/1/1950	12/3/1/2999
8580	Transcervical ablation of uterine fibroid(s), including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
00000	\ //		2/ 15/2024	12/31/2999
	intraoperative ultrasound guidance and monitoring,	Submit for Recommended Clinical Review to avoid post-service review.		
0750	radiofrequency	Non-Occupant December 1 and 1	4/45/0000	40/04/0000
8750	Tubotubal anastomosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/15/2008	12/31/2999
		service review.		

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
0699	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
1630	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
1630	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
1635	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
1645	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
1736	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
1737	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
1783	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
1783	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
1783	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
1889	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
1891	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
1892	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

62263	Percutaneous lysis of epidural adhesions using solution injection	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	(eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	0, 1, 2022	12/0 //2000
	days			
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).		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

64596	Insertion or replacement of percutaneous electrode array,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	peripheral nerve, with integrated neurostimulator, including	Submit for Recommended Clinical Review to avoid post-service review.		
	imaging guidance, when performed; initial electrode array			
1597	Insertion or replacement of percutaneous electrode array,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	peripheral nerve, with integrated neurostimulator, including	Submit for Recommended Clinical Review to avoid post-service review.		
	imaging guidance, when performed; each additional electrode			
	array (List separately in addition to code for primary procedure)			
624	Destruction by neurolytic agent, genicular nerve branches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2023	12/31/2999
	including imaging guidance, when performed	Submit for Recommended Clinical Review to avoid post-service review.		
628	Thermal destruction of intraosseous basivertebral nerve,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	including all imaging guidance; first 2 vertebral bodies, lumbar or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	sacral	Policy (CPCP).		
1628	Thermal destruction of intraosseous basivertebral nerve,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	including all imaging guidance; first 2 vertebral bodies, lumbar or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	sacral	Policy (CPCP).		
4629	Thermal destruction of intraosseous basivertebral nerve,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	including all imaging guidance; each additional vertebral body,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	lumbar or sacral (List separately in addition to code for primary	Policy (CPCP).		
	procedure)			
1629	Thermal destruction of intraosseous basivertebral nerve,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	including all imaging guidance; each additional vertebral body,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	lumbar or sacral (List separately in addition to code for primary	Policy (CPCP).		
	procedure)			
1640	Destruction by neurolytic agent; other peripheral nerve or branch	· · · · · · · · · · · · · · · · · · ·	5/15/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
4809	Sympathectomy, thoracolumbar		5/19/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
		service review.		
5767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5772	Corneal relaxing incision for correction of surgically induced	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
	astigmatism	Submit for Recommended Clinical Review to avoid post-service review.		
5775	Corneal wedge resection for correction of surgically induced	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
	astigmatism	Submit for Recommended Clinical Review to avoid post-service review.		
5785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
6174	Transluminal dilation of aqueous outflow canal (eg,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2012	12/31/2999
	canaloplasty); without retention of device or stent	Submit for Recommended Clinical Review to avoid post-service review.		101011000
3175	Transluminal dilation of aqueous outflow canal (eg,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2012	12/31/2999
	canaloplasty); with retention of device or stent	Submit for Recommended Clinical Review to avoid post-service review.		
6179	Aqueous shunt to extraocular equatorial plate reservoir, external	ı	1/1/2015	12/31/2999
	approach; without graft	Submit for Recommended Clinical Review to avoid post-service review.		
6180	Aqueous shunt to extraocular equatorial plate reservoir, external	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2021	12/31/2999
	approach; with graft	Submit for Recommended Clinical Review to avoid post-service review.		
6183	Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	extraocular reservoir, external approach	Submit for Recommended Clinical Review to avoid post-service review.		

66989	Extracapsular cataract removal with insertion of intraocular lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2022	12/31/2999
	prosthesis (1-stage procedure), manual or mechanical	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
991	Extracapsular cataract removal with insertion of intraocular lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2022	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
	(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			
028	Intravitreal injection of a pharmacologic agent (separate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	1/31/2024
	procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
516	Suprachoroidal space injection of pharmacologic agent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	(separate procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
900	Repair of brow ptosis (supraciliary, mid-forehead or coronal		9/24/2012	2/14/2024
	approach)	Submit for Recommended Clinical Review to avoid post-service review.		
901	Repair of blepharoptosis; frontalis muscle technique with suture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	or other material (eg, banked fascia)	Submit for Recommended Clinical Review to avoid post-service review.		
902	Repair of blepharoptosis; frontalis muscle technique with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	autologous fascial sling (includes obtaining fascia)	Submit for Recommended Clinical Review to avoid post-service review.		
903	Repair of blepharoptosis; (tarso) levator resection or		1/1/2005	12/31/2999
	advancement, internal approach	Submit for Recommended Clinical Review to avoid post-service review.		
904	Repair of blepharoptosis; (tarso) levator resection or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	advancement, external approach	Submit for Recommended Clinical Review to avoid post-service review.		
'906	Repair of blepharoptosis; superior rectus technique with fascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	sling (includes obtaining fascia)	Submit for Recommended Clinical Review to avoid post-service review.		
908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	levator resection (eg, Fasanella-Servat type)	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
9090	Ear piercing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2020	12/31/2999
200		service review.	4/4/4050	40/04/0000
300	Otoplasty, protruding ear, with or without size reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	444540004	10/01/0000
705	Nasopharyngoscopy, surgical, with dilation of eustachian tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2021	12/31/2999
700	(ie, balloon dilation); unilateral	Submit for Recommended Clinical Review to avoid post-service review.	4/45/0004	40/04/0000
706	Nasopharyngoscopy, surgical, with dilation of eustachian tube	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/15/2021	12/31/2999
740	(ie, balloon dilation); bilateral	Submit for Recommended Clinical Review to avoid post-service review.	40/45/0000	40/04/2000
9716	Implantation, osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/15/2022	12/31/2999
	transcutaneous attachment to external speech processor, within	Submit for Recommended Clinical Review to avoid post-service review.		
	the mastoid and/or resulting in removal of less than 100 sq mm			
	surface area of bone deep to the outer cranial cortex			

69719	Replacement (including removal of existing device),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/15/2022	12/31/2999
	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	Submit for Recommended Clinical Review to avoid post-service review.		
	area of bone deep to the outer cranial cortex			
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	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
20720	cranial cortex	MD Criteria: Draggedour / agreeige provides and agreeige to Madical Balicy Criteria	4/4/0000	40/04/0000
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	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

83701	Lipoprotein, blood; high resolution fractionation and quantitation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	of lipoproteins including lipoprotein subclasses when performed	review. Check EIU policy, which is one of our Clinical Payment and Coding	07.172020	, 0 ., _ 000
	(eg, electrophoresis, ultracentrifugation)	Policy (CPCP).		
3704	Lipoprotein, blood; quantitation of lipoprotein particle number(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	(eg, by nuclear magnetic resonance spectroscopy), includes	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	lipoprotein particle subclass(es), when performed	Policy (CPCP).		
3704	Lipoprotein, blood; quantitation of lipoprotein particle number(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	(eg, by nuclear magnetic resonance spectroscopy), includes	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	lipoprotein particle subclass(es), when performed	Policy (CPCP).		
3722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	J	review. Check EIU policy, which is one of our Clinical Payment and Coding		,
		Policy (CPCP).		
3987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1112	Evaluation of cervicovaginal fluid for specific amniotic fluid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	protein(s) (eg, placental alpha microglobulin-1 [PAMG-1],	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	placental protein 12 [PP12], alpha-fetoprotein), qualitative, each			
	specimen			
1112	Evaluation of cervicovaginal fluid for specific amniotic fluid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	protein(s) (eg, placental alpha microglobulin-1 [PAMG-1],	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	placental protein 12 [PP12], alpha-fetoprotein), qualitative, each			
	specimen			
1431	Thromboxane metabolite(s), including thromboxane if	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	performed, urine	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1431	Thromboxane metabolite(s), including thromboxane if	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	performed, urine	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
3001	Allergen specific IgG quantitative or semiquantitative, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	allergen	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	Ŭ	Policy (CPCP).		
3001	Allergen specific IgG quantitative or semiquantitative, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	allergen	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

86328	Immunoassay for infectious agent antibody(ies), qualitative or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
00020	semiquantitative, single-step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	0, 1,2020	12,0 1/2000
	(coronavirus disease [COVID-19])			
86328	Immunoassay for infectious agent antibody(ies), qualitative or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	semiquantitative, single-step method (eg, reagent strip); severe	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	Policy (CPCP).		
	(coronavirus disease [COVID-19])			
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	induced blastogenesis	Submit for Recommended Clinical Review to avoid post-service review.		
86408	Neutralizing antibody, severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	screen	Policy (CPCP).		
86408	Neutralizing antibody, severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]);	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	screen	Policy (CPCP).		
86409	Neutralizing antibody, severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]);	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	titer	Policy (CPCP).		
86409	Neutralizing antibody, severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]);	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	titer	Policy (CPCP).		
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	2) (coronavirus disease [COVID-19]) antibody, quantitative	review. Check EIU policy, which is one of our Clinical Payment and Coding		
00110		Policy (CPCP).	0///0000	10/01/0000
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	2) (coronavirus disease [COVID-19]) antibody, quantitative	review. Check EIU policy, which is one of our Clinical Payment and Coding		
00700	A. 4: h	Policy (CPCP).	0/4/0000	40/04/0000
86769	Antibody; severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2023	12/31/2999
	(SARS-CoV-2) (coronavirus disease [COVID-19])	· · · · · · · · · · · · · · · · · · ·		
86769	Antibody; severe acute respiratory syndrome coronavirus 2	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
00109	(SARS-CoV-2) (coronavirus disease [COVID-19])	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2023	12/3/1/2999
	(Onito-001-2) (colollavilus disease [COVID-18])	Policy (CPCP).		
86910	Blood typing, for paternity testing, per individual; ABO, Rh and		1/1/1950	12/31/2999
00010	IMN	service review.	17 17 1000	12/01/2000
86911			1/1/1950	12/31/2999
	antigen system	service review.	., 1, 1000	12/01/2000
87505	Infectious agent detection by nucleic acid (DNA or RNA);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2020	12/31/2999
0.000	gastrointestinal pathogen (eg, Clostridium difficile, E. coli,	Submit for Recommended Clinical Review to avoid post-service review.	0, 10,2020	12/01/2000
	Salmonella, Shigella, norovirus, Giardia), includes multiplex	Capital 101 1 (Cookin Horida Califold 1 (Colon to dvoid pool col vice 10 vice).		
	reverse transcription, when performed, and multiplex amplified			
	probe technique, multiple types or subtypes, 3-5 targets			
	Throne recultings, mainthe types of santypes, 3-3 talkets	l		

87506	Infectious agent detection by nucleic acid (DNA or RNA);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2020	12/31/2999
	gastrointestinal pathogen (eg, Clostridium difficile, E. coli,	Submit for Recommended Clinical Review to avoid post-service review.		1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	Salmonella, Shigella, norovirus, Giardia), includes multiplex	Custinic for Procediminaria and Chinical Provider to avoid poor convicts for the Convictor for the Con		
	reverse transcription, when performed, and multiplex amplified			
	probe technique, multiple types or subtypes, 6-11 targets			
37507	Infectious agent detection by nucleic acid (DNA or RNA);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2020	12/31/2999
57 30 7	• • • • • • • • • • • • • • • • • • • •	Submit for Recommended Clinical Review to avoid post-service review.	3/13/2020	12/31/2999
	gastrointestinal pathogen (eg, Clostridium difficile, E. coli,	Submit for Recommended Clinical Review to avoid post-service review.		
	Salmonella, Shigella, norovirus, Giardia), includes multiplex			
	reverse transcription, when performed, and multiplex amplified			
2000	probe technique, multiple types or subtypes, 12-25 targets		4/4/4050	40/04/0000
38000	Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
88005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
88007	Necropsy (autopsy), gross examination only; with brain and	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	spinal cord	service review.		
88012	Necropsy (autopsy), gross examination only; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
38014	Necropsy (autopsy), gross examination only; stillborn or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	newborn with brain	service review.		
38016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	7,	service review.		
8020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	(uatopo)/, g. 555 a.u515555p.is,515	service review.	., .,	12/01/2000
88025	Necropsy (autopsy), gross and microscopic; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
00020	(dutopoy), gross and misroscopic, with stain	Iservice review.	17 17 1000	12/01/2000
38027	Necropsy (autopsy), gross and microscopic; with brain and	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
00021	spinal cord	service review.	1/1/1930	12/31/2999
38028	Necropsy (autopsy), gross and microscopic; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
00020	Necropsy (autopsy), gross and microscopic, main with brain	•	1/1/1930	12/31/2999
20000	Name of the second seco	Service review.	4/4/4050	40/04/0000
38029	Necropsy (autopsy), gross and microscopic; stillborn or newborn		1/1/1950	12/31/2999
2000	with brain	service review.	4/4/4050	40/04/0000
38036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
38037	Necropsy (autopsy), limited, gross and/or microscopic; single	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	organ	service review.		
88040	Necropsy (autopsy); forensic examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
88045	Necropsy (autopsy); coroner's call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
38099	Unlisted necropsy (autopsy) procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
88375	Optical endomicroscopic image(s), interpretation and report, real	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	time or referred, each endoscopic session	review. Check EIU policy, which is one of our Clinical Payment and Coding	,	
	and of foldifica, oddir offactoopio occolori	Policy (CPCP).		
38375	Ontical endomicrosconic image(s) interpretation and report, real	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
,0010		review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 1/2020	12/01/2000
	time or referred, each endoscopic session			
00050	Cryoprocomotion, ambryo(a)	Policy (CPCP).	1/1/2007	10/01/0000
9258	Cryopreservation; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2007	12/31/2999
		service review.		

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89259	Cryopreservation; sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2007	12/31/2999
89335	Cryopreservation, reproductive tissue, testicular		3/20/2018	12/31/2999
39337	Cryopreservation, mature oocyte(s)		1/1/2019	12/31/2999
9342	Storage (per year); embryo(s)		3/20/2018	12/31/2999
9343	Storage (per year); sperm/semen		3/20/2018	12/31/2999
9344	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
9346	Storage (per year); oocyte(s)		3/20/2018	12/31/2999
9352	Thawing of cryopreserved; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	3/20/2018	12/31/2999
9353	Thawing of cryopreserved; sperm/semen, each aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	3/20/2018	12/31/2999
9354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
9356	Thawing of cryopreserved; oocytes, each aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
)378	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
0666	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
0667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	7/1/2010	12/31/2999
0668	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
0683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	5/31/2024
0867	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
0868	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
0869	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
0875	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
0876	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
0880	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

90885	Psychiatric evaluation of hospital records, other psychiatric	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	service review.		
90889	Preparation of report of patient's psychiatric status, history,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	treatment, or progress (other than for legal or consultative	service review.		
	purposes) for other individuals, agencies, or insurance carriers			
90901	Biofeedback training by any modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
90912	Biofeedback training, perineal muscles, anorectal or urethral		4/1/2021	12/31/2999
	sphincter, including EMG and/or manometry, when performed;	Submit for Recommended Clinical Review to avoid post-service review.		
	initial 15 minutes of one-on-one physician or other qualified			
	health care professional contact with the patient			
90913	Biofeedback training, perineal muscles, anorectal or urethral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2021	12/31/2999
	sphincter, including EMG and/or manometry, when performed;	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
91065	Breath hydrogen or methane test (eg, for detection of lactase	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	deficiency, fructose intolerance, bacterial overgrowth, or oro-	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	cecal gastrointestinal transit)	Policy (CPCP).		
91065	Breath hydrogen or methane test (eg, for detection of lactase	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	deficiency, fructose intolerance, bacterial overgrowth, or oro-	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	cecal gastrointestinal transit)	Policy (CPCP).		
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	endoscopy), esophagus through ileum, with interpretation and	Submit for Recommended Clinical Review to avoid post-service review.		
	report			
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	endoscopy), esophagus with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	endoscopy), esophagus with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91112	Gastrointestinal transit and pressure measurement, stomach	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	through colon, wireless capsule, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91112	Gastrointestinal transit and pressure measurement, stomach	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	through colon, wireless capsule, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	endoscopy), colon, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	endoscopy), colon, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
91117	Colon motility (manometric) study, minimum 6 hours continuous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
	recording (including provocation tests, eg, meal, intracolonic	Submit for Recommended Clinical Review to avoid post-service review.		
	balloon distension, pharmacologic agents, if performed), with			
	interpretation and report			

91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	0, 1, 2020	12/01/2000
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1133	Electrogastrography, diagnostic, transcutaneous; with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	provocative testing	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ľ	Policy (CPCP).		
1133	Electrogastrography, diagnostic, transcutaneous; with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	provocative testing	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2065	Orthoptic training; performed by a physician or other qualified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	11/1/2013	12/31/2999
	health care professional	service review.		
2132	Scanning computerized ophthalmic diagnostic imaging, anterior	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	segment, with interpretation and report, unilateral or bilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
92132	Scanning computerized ophthalmic diagnostic imaging, anterior	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	segment, with interpretation and report, unilateral or bilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2145	Corneal hysteresis determination, by air impulse stimulation,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	unilateral or bilateral, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2145	Corneal hysteresis determination, by air impulse stimulation,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	unilateral or bilateral, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2512	Nasal function studies (eg, rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
92512	Nasal function studies (eg, rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
25.15		Policy (CPCP).	= / / = /0.00 /	10/01/0000
92517	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	interpretation and report; cervical (cVEMP)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0547	Variable demonstration of the state of the s	Policy (CPCP).	E/4E/0004	40/04/0000
2517	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	interpretation and report; cervical (cVEMP)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
2518	Vestibular evoked myogenic potential (VEMP) testing, with	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	E/4E/2024	12/31/2999
2010		review. Check EIU policy, which is one of our Clinical Payment and Coding	5/15/2021	12/31/2999
	interpretation and report; ocular (oVEMP)	Policy (CPCP).		
2518	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
2010	interpretation and report; ocular (oVEMP)	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/13/2021	12/31/2999
	interpretation and report, ocular (UVEIVIF)	Policy (CPCP).		
2519	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
2010	interpretation and report; cervical (cVEMP) and ocular (oVEMP)	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2021	12/3/1/2333
	interpretation and report, cervical (CVEIVIF) and ocular (OVEIVIF)	· · ·		
2510	Vestibular evoked myogenic potential (VEMD) testing with	Policy (CPCP). FILL: Procedure/service not reimbursed by the Plan. Not subject to pre-service.	5/15/2021	12/31/2000
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	5/15/2021	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	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
	visual sway), including interpretation and report;			
92548	Computerized dynamic posturography sensory organization test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	(CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	sway, platform sway, eyes closed platform sway, platform and	Policy (CPCP).		
	visual sway), including interpretation and report;			
92549	Computerized dynamic posturography sensory organization test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	(CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	sway, platform sway, eyes closed platform sway, platform and	Policy (CPCP).		
	visual sway), including interpretation and report; with motor			
	control test (MCT) and adaptation test (ADT)			
92549		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	(CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	sway, platform sway, eyes closed platform sway, platform and	Policy (CPCP).		
	visual sway), including interpretation and report; with motor			
	control test (MCT) and adaptation test (ADT)			
92622	Diagnostic analysis, programming, and verification of an	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	auditory osseointegrated sound processor, any type; first 60	Submit for Recommended Clinical Review to avoid post-service review.		
	minutes			
92623	Diagnostic analysis, programming, and verification of an	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	auditory osseointegrated sound processor, any type; each	Submit for Recommended Clinical Review to avoid post-service review.		
	additional 15 minutes (List separately in addition to code for			
	primary procedure)			
92972	Percutaneous transluminal coronary lithotripsy (List separately	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	in addition to code for primary procedure)	Submit for Recommended Clinical Review to avoid post-service review.		
93050	Arterial pressure waveform analysis for assessment of central	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	arterial pressures, includes obtaining waveform(s), digitization	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and application of nonlinear mathematical transformations to	Policy (CPCP).		
	determine central arterial pressures and augmentation index,			
	with interpretation and report, upper extremity artery, non-			
	invasive			
93050		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	arterial pressures, includes obtaining waveform(s), digitization	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and application of nonlinear mathematical transformations to	Policy (CPCP).		
	determine central arterial pressures and augmentation index,			
	with interpretation and report, upper extremity artery, non-			
	invasive			
93150	Therapy activation of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	system, including all interrogation and programming	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93150	Therapy activation of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	system, including all interrogation and programming	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93150	Therapy activation of implanted phrenic nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	system, including all interrogation and programming	Submit for Recommended Clinical Review to avoid post-service review.		
93151		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	implanted phrenic nerve stimulator system	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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	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).		12/31/2999
3152	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
3152	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
3153	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
3153	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	Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
3229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional		1/1/2020	12/31/2999
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2005	12/31/2999

93660	Evaluation of cardiovascular function with tilt table evaluation,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	Submit for Recommended Clinical Review to avoid post-service review.		
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	lymphedema assessment(s)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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).		12/31/2999
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		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 preservice 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 preservice 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

95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
5065	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
5065	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).		12/31/2999
5700	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
5705	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
5706	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
5707	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
5708	Electroencephalogram (EEG), without video, review of data,	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
5709	Electroencephalogram (EEG), without video, review of data,	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
5710	Electroencephalogram (EEG), without video, review of data,	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
5711	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
5712	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
5713	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
5714	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
5715	Electroencephalogram with video (VEEG), review of data,	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

95716	Electroencephalogram with video (VEEG), review of data,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	technical description by EEG technologist, each increment of 12-	Submit for Recommended Clinical Review to avoid post-service review.		
	26 hours; with continuous, real-time monitoring and			
	maintenance			
5717	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	events, analysis of spike and seizure detection, interpretation			
	and report, 2-12 hours of EEG recording; without video			
5718	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	events, analysis of spike and seizure detection, interpretation			
	and report, 2-12 hours of EEG recording; with video (VEEG)			
5719	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
5720	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
5721	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
5722	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
5723	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
5724	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
5725	Electroencephalogram (EEG), continuous recording, physician	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2023	12/31/2999
	or other qualified health care professional review of recorded	Submit for Recommended Clinical Review to avoid post-service review.		
	events, analysis of spike and seizure detection, interpretation,			
	and summary report, complete study; greater than 84 hours of			
	EEG recording, without video			

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

5967	Magnetoencephalography (MEG), recording and analysis; for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	evoked magnetic fields, each additional modality (eg. sensory,	Submit for Recommended Clinical Review to avoid post-service review.		
	motor, language, or visual cortex localization) (List separately in	'		
	addition to code for primary procedure)			
981	Electronic analysis of implanted neurostimulator pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	system (eg, rate, pulse amplitude and duration, configuration of	Submit for Recommended Clinical Review to avoid post-service review.		
	wave form, battery status, electrode selectability, output	'		
	modulation, cycling, impedance and patient measurements)			
	gastric neurostimulator pulse generator/transmitter; subsequent,			
	without reprogramming			
982	Electronic analysis of implanted neurostimulator pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	system (eg, rate, pulse amplitude and duration, configuration of	Submit for Recommended Clinical Review to avoid post-service review.		
	wave form, battery status, electrode selectability, output	'		
	modulation, cycling, impedance and patient measurements)			
	gastric neurostimulator pulse generator/transmitter; subsequent,			
	with reprogramming			
0000	Comprehensive computer-based motion analysis by video-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2010	12/31/2999
	taping and 3D kinematics;	Submit for Recommended Clinical Review to avoid post-service review.		
6001	Comprehensive computer-based motion analysis by video-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2010	12/31/2999
	taping and 3D kinematics; with dynamic plantar pressure	Submit for Recommended Clinical Review to avoid post-service review.		
	measurements during walking			
6002	Dynamic surface electromyography, during walking or other	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2010	12/31/2999
	functional activities, 1-12 muscles	Submit for Recommended Clinical Review to avoid post-service review.		
3003	Dynamic fine wire electromyography, during walking or other	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2010	12/31/2999
	functional activities, 1 muscle	Submit for Recommended Clinical Review to avoid post-service review.		
6004	Review and interpretation by physician or other qualified health	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2010	12/31/2999
	care professional of comprehensive computer-based motion	Submit for Recommended Clinical Review to avoid post-service review.		
	analysis, dynamic plantar pressure measurements, dynamic	'		
	surface electromyography during walking or other functional			
	activities, and dynamic fine wire electromyography, with written			
	report			
3547	Intraoperative hyperthermic intraperitoneal chemotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	(HIPEC) procedure, including separate incision(s) and closure,	Submit for Recommended Clinical Review to avoid post-service review.		
	when performed; first 60 minutes (List separately in addition to	<u>'</u>		
	code for primary procedure)			
6548	Intraoperative hyperthermic intraperitoneal chemotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	(HIPEC) procedure, including separate incision(s) and closure,	Submit for Recommended Clinical Review to avoid post-service review.		
	when performed; each additional 30 minutes (List separately in	, , , , , , , , , , , , , , , , , , , ,		
	addition to code for primary procedure)			
6571	Photodynamic therapy by endoscopic application of light to	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	ablate abnormal tissue via activation of photosensitive drug(s);	Submit for Recommended Clinical Review to avoid post-service review.		
	each additional 15 minutes (List separately in addition to code	, , , , , , , , , , , , , , , , , , , ,		
	for endoscopy or bronchoscopy procedures of lung and			
	gastrointestinal tract)			
6912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2009	12/31/2999
	(- /	Submit for Recommended Clinical Review to avoid post-service review.		
6913	Photochemotherapy (Goeckerman and/or PUVA) for severe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2010	12/31/2999
	photoresponsive dermatoses requiring at least 4-8 hours of care			
	under direct supervision of the physician (includes application of	, , , , , , , , , , , , , , , , , , , ,		
	medication and dressings)		1	1

97037	Application of a modality to 1 or more areas; low-level laser	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
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).		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 preservice 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 preservice review.		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 preservice 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 preservice 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	service review.		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 preservice review.		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 preservice review.	1/1/1950	12/31/2999
99075	Medical testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice review.	1/1/1950	12/31/2999

99360	Standby service, requiring prolonged attendance, each 30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	service review.		
99450	Basic life and/or disability examination that includes:	, , ,	1/1/1950	12/31/2999
	Measurement of height, weight, and blood pressure; Completion	service review.		
	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			
99455	documentation/certificates. Work related or medical disability examination by the treating	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
30-100	physician that includes: Completion of a medical history	service review.	17 17 1000	12/01/2000
	commensurate with the patient's condition; Performance of an	5511155 15415W.		
	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.			
99456		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	treating physician that includes: Completion of a medical history	service review.		
	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.			
99509	Home visit for assistance with activities of daily living and	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
	personal care	service review.		
0052U		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2018	12/31/2999
	of lipoproteins, including all five major lipoprotein classes and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	subclasses of HDL, LDL, and VLDL by vertical auto profile	Policy (CPCP).		
005011	ultracentrifugation	FILL Developed and the state of	7/4/0040	40/04/0000
0052U		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	7/1/2018	12/31/2999
	of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile	Policy (CPCP).		
	ultracentrifugation	rolley (cror).		
0054T	Computer-assisted musculoskeletal surgical navigational	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	orthopedic procedure, with image-guidance based on	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic images (List separately in addition to code for	Policy (CPCP).		
	primary procedure)			
0054T	Computer-assisted musculoskeletal surgical navigational	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	orthopedic procedure, with image-guidance based on	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic images (List separately in addition to code for	Policy (CPCP).		
00557	primary procedure)		0/4/0000	40/04/0000
0055T	Computer-assisted musculoskeletal surgical navigational	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		

0055T	Computer-assisted musculoskeletal surgical navigational	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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	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

0105U	Nephrology (chronic kidney disease), multiplex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2024	12/31/2999
	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,	Submit for Recommended Clinical Review to avoid post-service review.		
	and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)			
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		EIU: Procedure/service not 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	EIU: Procedure/service not reimbursed by the Plan. Not subject 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		EIU: Procedure/service not 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	EIU: Procedure/service not 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	EIU: Procedure/service not 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		EIU: Procedure/service not 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

0198T	Measurement of ocular blood flow by repetitive intraocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	pressure sampling, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
2200T	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
)201T	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
)202T	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
)207T	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).		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
)219T	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
)220T	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

0222T	Placement of a posterior intrafacet implant(s), unilateral or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	bilateral, including imaging and placement of bone graft(s) or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	synthetic device(s), single level; each additional vertebral	Policy (CPCP).		
	segment (List separately in addition to code for primary			
	procedure)			
0224U	Antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	(SARS-CoV-2) (Coronavirus disease [COVID-19]), includes	review. Check EIU policy, which is one of our Clinical Payment and Coding		
000411	titer(s), when performed Antibody, severe acute respiratory syndrome coronavirus 2	Policy (CPCP).	0/4/0000	40/04/0000
0224U	(SARS-CoV-2) (Coronavirus disease [COVID-19]), includes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2023	12/31/2999
	titer(s), when performed	Policy (CPCP).		
0226U	Surrogate viral neutralization test (sVNT), severe acute	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
02200		review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2023	12/31/2999
	disease [COVID-19]), ELISA, plasma, seru	Policy (CPCP).		
0226U	Surrogate viral neutralization test (sVNT), severe acute	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
02200		review. Check EIU policy, which is one of our Clinical Payment and Coding	0/ 1/2020	12/01/2000
	disease [COVID-19]), ELISA, plasma, seru	Policy (CPCP).		
0232T	Injection(s), platelet rich plasma, any site, including image	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	guidance, harvesting and preparation when performed	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0232T	Injection(s), platelet rich plasma, any site, including image	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	guidance, harvesting and preparation when performed	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0253T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
	extraocular reservoir, internal approach, into the suprachoroidal	Submit for Recommended Clinical Review to avoid post-service review.		
	space			
0263T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including ultrasound guidance, if performed; complete procedure	Policy (CPCP).		
0000	including unilateral or bilateral bone marrow harvest	The December of the state of th	0/4/0000	40/04/0000
0263T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	Policy (CPCP).		
0264T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/1/2020	12/31/2999
02041	preparation of harvested cells, multiple injections, one leg,	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 1/2020	12/31/2999
	including ultrasound guidance, if performed; complete procedure			
	excluding bone marrow harvest	li olicy (cr cr).		
0264T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
•	preparation of harvested cells, multiple injections, one leg,	review. Check EIU policy, which is one of our Clinical Payment and Coding		, 0 ., _000
	including ultrasound guidance, if performed; complete procedure			
	excluding bone marrow harvest	, (/-		
0265T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including ultrasound guidance, if performed; unilateral or	Policy (CPCP).		
	bilateral bone marrow harvest only for intramuscular autologous			
	bone marrow cell therapy			

0265T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	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	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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

0274T	Percutaneous laminotomy/laminectomy (interlaminar approach)		1/1/2023	12/31/2999
	for decompression of neural elements, (with or without	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ligamentous resection, discectomy, facetectomy and/or	Policy (CPCP).		
	foraminotomy), any method, under indirect image guidance (eg,			
	fluoroscopic, CT), single or multiple levels, unilateral or bilateral;			
	cervical or thoracic			
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	for decompression of neural elements, (with or without	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ligamentous resection, discectomy, facetectomy and/or	Policy (CPCP).		
	foraminotomy), any method, under indirect image guidance (eg,			
	fluoroscopic, CT), single or multiple levels, unilateral or bilateral;			
	lumbar			
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	for decompression of neural elements, (with or without	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ligamentous resection, discectomy, facetectomy and/or	Policy (CPCP).		
	foraminotomy), any method, under indirect image guidance (eg,			
	fluoroscopic, CT), single or multiple levels, unilateral or bilateral;			
00707	lumbar		40/4/0000	10/01/0000
0278T	Transcutaneous electrical modulation pain reprocessing (eg,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
00707	of electrodes)	Policy (CPCP).	40/4/0000	40/04/0000
0278T	Transcutaneous electrical modulation pain reprocessing (eg,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	scrambler therapy), each treatment session (includes placement	· · ·		
0308T	of electrodes) Insertion of ocular telescope prosthesis including removal of	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2012	12/31/2999
03061	crystalline lens or intraocular lens prosthesis	Submit for Recommended Clinical Review to avoid post-service review.	77 1720 12	12/31/2999
0312U	Autoimmune diseases (eg, systemic lupus erythematosus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
03120	[SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound	review. Check EIU policy, which is one of our Clinical Payment and Coding	4/ 1/2022	12/31/2999
	complement activation products using enzyme-linked	Policy (CPCP).		
	immunosorbent immunoassay (ELISA), flow cytometry and	l olicy (or or).		
	indirect immunofluorescence, serum, or plasma and whole			
	blood, individual components reported along with an algorithmic			
	SLE-likelihood assessment			
0322U	Neurology (autism spectrum disorder [ASD]), quantitative	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/15/2024	12/31/2999
00220	measurements of 14 acyl carnitines and microbiome-derived	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 10/2021	12/01/2000
	metabolites, liquid chromatography with tandem mass	Policy (CPCP).		
	spectrometry (LC-MS/MS), plasma, results reported as negative	. 55) (6 6).		
	or positive for risk of metabolic subtypes associated with ASD			
	5. PESIATE TOT HOLD INCLUSING GUSTYPOO GOODSIGHOU WITH NOD			
0322U	Neurology (autism spectrum disorder [ASD]), quantitative	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/15/2024	12/31/2999
	measurements of 14 acyl carnitines and microbiome-derived	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	metabolites, liquid chromatography with tandem mass	Policy (CPCP).		
	spectrometry (LC-MS/MS), plasma, results reported as negative			
	or positive for risk of metabolic subtypes associated with ASD			
	,			

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	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		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).		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

0345T	Transcatheter mitral valve repair percutaneous approach via the		2/15/2016	12/31/2999
	coronary sinus	Submit for Recommended Clinical Review to avoid post-service review.		
347T	Placement of interstitial device(s) in bone for radiostereometric	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	analysis (RSA)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
347T	Placement of interstitial device(s) in bone for radiostereometric	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	analysis (RSA)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
348T	Radiologic examination, radiostereometric analysis (RSA);	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	spine, (includes cervical, thoracic and lumbosacral, when	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	performed)	Policy (CPCP).		
48T	Radiologic examination, radiostereometric analysis (RSA);	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	spine, (includes cervical, thoracic and lumbosacral, when	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	performed)	Policy (CPCP).		
49T	Radiologic examination, radiostereometric analysis (RSA);	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	upper extremity(ies), (includes shoulder, elbow, and wrist, when			
	performed)	Policy (CPCP).		
349T	Radiologic examination, radiostereometric analysis (RSA);	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	upper extremity(ies), (includes shoulder, elbow, and wrist, when	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	performed)	Policy (CPCP).		
350T	Radiologic examination, radiostereometric analysis (RSA): lower	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	extremity(ies), (includes hip, proximal femur, knee, and ankle,	review. Check EIU policy, which is one of our Clinical Payment and Coding		1-7-11-11-1
	when performed)	Policy (CPCP).		
350T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	extremity(ies), (includes hip, proximal femur, knee, and ankle,	review. Check EIU policy, which is one of our Clinical Payment and Coding		1
	when performed)	Policy (CPCP).		
352T	Optical coherence tomography of breast or axillary lymph node,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	excised tissue, each specimen; interpretation and report, real-	Submit for Recommended Clinical Review to avoid post-service review.	,	1-7-11-11
	time or referred			
354T	Optical coherence tomography of breast, surgical cavity;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	interpretation and report, real-time or referred	Submit for Recommended Clinical Review to avoid post-service review.	,	,
358T	Bioelectrical impedance analysis whole body composition	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	assessment, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		1
	assessing in a management and report	Policy (CPCP).		
358T	Bioelectrical impedance analysis whole body composition	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	assessment, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding	, .,	12/01/2000
	assessment, man interpretation and report	Policy (CPCP).		
369U	Infectious agent detection by nucleic acid (DNA and RNA),	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	gastrointestinal pathogens, 31 bacterial, viral, and parasitic	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	organisms and identification of 21 associated antibiotic-	Policy (CPCP).		
	resistance genes, multiplex amplified probe technique	i only (or or).		
369U	Infectious agent detection by nucleic acid (DNA and RNA),	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	gastrointestinal pathogens, 31 bacterial, viral, and parasitic	review. Check EIU policy, which is one of our Clinical Payment and Coding	J, 10/2024	12/01/2000
	organisms and identification of 21 associated antibiotic-	Policy (CPCP).		
	resistance genes, multiplex amplified probe technique	i olicy (or or).		
369U	Infectious agent detection by nucleic acid (DNA and RNA),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2024	5/14/2024
0000	gastrointestinal pathogens, 31 bacterial, viral, and parasitic	Submit for Recommended Clinical Review to avoid post-service review.	2, 1/2024	J/ 17/2024
		Submit for Recommended Cililical Review to avoid post-service review.		
	organisms and identification of 21 associated antibiotic-			
	resistance genes, multiplex amplified probe technique			1

and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days;	review. Check EIU policy, which is one of our Clinical Payment and Coding		
transmitted to a remote surveillance center for up to 30 days:			
	Policy (CPCP).		
review and interpretation with report by a physician or other			
qualified health care professional			
Visual field assessment, with concurrent real time data analysis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
and accessible data storage with patient initiated data	review. Check EIU policy, which is one of our Clinical Payment and Coding		
transmitted to a remote surveillance center for up to 30 days;	Policy (CPCP).		
review and interpretation with report by a physician or other			
qualified health care professional			
		12/1/2020	12/31/2999
and accessible data storage with patient initiated data	review. Check EIU policy, which is one of our Clinical Payment and Coding		
transmitted to a remote surveillance center for up to 30 days;	Policy (CPCP).		
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			
Visual field assessment, with concurrent real time data analysis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
and accessible data storage with patient initiated data	review. Check EIU policy, which is one of our Clinical Payment and Coding		
transmitted to a remote surveillance center for up to 30 days;	Policy (CPCP).		
technical support and patient instructions, surveillance, analysis,	,		
Endoscopic retrograde cholangiopancreatography (ERCP), with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
optical endomicroscopy (List separately in addition to code for	review. Check EIU policy, which is one of our Clinical Payment and Coding		
primary procedure)	Policy (CPCP).		
Endoscopic retrograde cholangiopancreatography (ERCP), with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
optical endomicroscopy (List separately in addition to code for	review. Check EIU policy, which is one of our Clinical Payment and Coding		
primary procedure)	Policy (CPCP).		
Magnetic resonance image guided high intensity focused	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2020	12/31/2999
ultrasound (MRgFUS), stereotactic ablation lesion, intracranial	Submit for Recommended Clinical Review to avoid post-service review.		
for movement disorder including stereotactic navigation and			
frame placement when performed			
Collagen cross-linking of cornea, including removal of the	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2017	12/31/2999
corneal epithelium, when performed, and intraoperative	Submit for Recommended Clinical Review to avoid post-service review.		
pachymetry, when performed	'		
Nephrology (diabetic chronic kidney disease [CKD]), multiplex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2024	12/31/2999
	'		
	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
			1-1-1-1-1
parameters; pulse generator with transvenous electrodes			
	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 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 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 Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed 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 kid	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. 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 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). Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Magnetic resonance image guided high intensity focused ultrasound (MRGPLUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed. Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed. Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemilluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (STNFR), soluble tumor necrosis factor receptor 2 (STNFR), and kidney function linsertion or replacement of permanent cardiac contractility modulation syste	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. Fig. 12. Forcedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Forcedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Forcedure/service not reimbursed by the Plan. Not subject to pre-service professional 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 Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic analysis and resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic contractility eachymenty, when performed Neptrology (dilabetic chronic kidney diversed again, including removal of the corneal epithelium, when performed) Neptrology (dilabetic chronic kidney diversed against Medical Policy Criteria. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinic

0409T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
0.001	modulation system, including contractility evaluation when	Submit for Recommended Clinical Review to avoid post-service review.	0/10/2021	12/01/2000
	performed, and programming of sensing and therapeutic	Cushine for recommended clinical review to avoid post service review.		
	parameters: pulse generator only			
410T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	modulation system, including contractility evaluation when	Submit for Recommended Clinical Review to avoid post-service review.		
	performed, and programming of sensing and therapeutic			
	parameters; atrial electrode only			
111T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	modulation system, including contractility evaluation when	Submit for Recommended Clinical Review to avoid post-service review.		
	performed, and programming of sensing and therapeutic	· ·		
	parameters; ventricular electrode only			
12T	Removal of permanent cardiac contractility modulation system;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	pulse generator only	Submit for Recommended Clinical Review to avoid post-service review.		
13T	Removal of permanent cardiac contractility modulation system;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	transvenous electrode (atrial or ventricular)	Submit for Recommended Clinical Review to avoid post-service review.		
14T	Removal and replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	modulation system pulse generator only	Submit for Recommended Clinical Review to avoid post-service review.		
15T	Repositioning of previously implanted cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	modulation transvenous electrode (atrial or ventricular lead)	Submit for Recommended Clinical Review to avoid post-service review.		
16T	Relocation of skin pocket for implanted cardiac contractility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	modulation pulse generator	Submit for Recommended Clinical Review to avoid post-service review.		
17T	Programming device evaluation (in person) with iterative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	adjustment of the implantable device to test the function of the	Submit for Recommended Clinical Review to avoid post-service review.		
	device and select optimal permanent programmed values with	'		
	analysis, including review and report, implantable cardiac			
	contractility modulation system			
18T	Interrogation device evaluation (in person) with analysis, review	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	and report, includes connection, recording and disconnection	Submit for Recommended Clinical Review to avoid post-service review.		
	per patient encounter, implantable cardiac contractility	'		
	modulation system			
122T	Tactile breast imaging by computer-aided tactile sensors,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	unilateral or bilateral	Submit for Recommended Clinical Review to avoid post-service review.		
40T	Ablation, percutaneous, cryoablation, includes imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
	guidance; upper extremity distal/peripheral nerve	Submit for Recommended Clinical Review to avoid post-service review.		
41T	Ablation, percutaneous, cryoablation, includes imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
	guidance; lower extremity distal/peripheral nerve	Submit for Recommended Clinical Review to avoid post-service review.		
42T	Ablation, percutaneous, cryoablation, includes imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
	guidance; nerve plexus or other truncal nerve (eg, brachial	Submit for Recommended Clinical Review to avoid post-service review.		
	plexus, pudendal nerve)	'		
49T	Insertion of aqueous drainage device, without extraocular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2020	12/31/2999
	reservoir, internal approach, into the subconjunctival space;	Submit for Recommended Clinical Review to avoid post-service review.		
	initial device	'		
50T	Insertion of aqueous drainage device, without extraocular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2021	12/31/2999
	reservoir, internal approach, into the subconjunctival space;	Submit for Recommended Clinical Review to avoid post-service review.		
	each additional device (List separately in addition to code for	, , , , , , , , , , , , , , , , , , , ,		
	primary procedure)			
64T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	,	Policy (CPCP).		

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	12/1/2020	12/31/2999
		Policy (CPCP).		
472T	Device evaluation, interrogation, and initial programming of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	intraocular retinal electrode array (eg, retinal prosthesis), in	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	person, with iterative adjustment of the implantable device to	Policy (CPCP).		
	test functionality, select optimal permanent programmed values	1 51154 (51 51).		
	with analysis, including visual training, with review and report by			
	a qualified health care professional			
472T	Device evaluation, interrogation, and initial programming of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	9/14/2024
7/21	intraocular retinal electrode array (eg, retinal prosthesis), in	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	3/14/2024
	person, with iterative adjustment of the implantable device to	· · ·		
		Policy (CPCP).		
	test functionality, select optimal permanent programmed values			
	with analysis, including visual training, with review and report by			
470T	a qualified health care professional	FILL December 4 and the state of the state o	40/4/0000	40/04/0000
473T	Device evaluation and interrogation of intraocular retinal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	electrode array (eg, retinal prosthesis), in person, including	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	reprogramming and visual training, when performed, with review	Policy (CPCP).		
	and report by a qualified health care professional			
473T	Device evaluation and interrogation of intraocular retinal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	9/14/2024
	electrode array (eg, retinal prosthesis), in person, including	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	reprogramming and visual training, when performed, with review	Policy (CPCP).		
	and report by a qualified health care professional			
174T	Insertion of anterior segment aqueous drainage device, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2017	12/31/2999
	creation of intraocular reservoir, internal approach, into the	Submit for Recommended Clinical Review to avoid post-service review.		
	supraciliary space	'		
479T	Fractional ablative laser fenestration of burn and traumatic scars	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
	for functional improvement; first 100 cm2 or part thereof, or 1%	Submit for Recommended Clinical Review to avoid post-service review.		1.2,2 2222
	of body surface area of infants and children			
480T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
1001	for functional improvement; each additional 100 cm2, or each	Submit for Recommended Clinical Review to avoid post-service review.	11/1/2010	12/01/2000
	additional 1% of body surface area of infants and children, or	Cashine for Recommended Chinical Review to avoid post service review.		
	part thereof (List separately in addition to code for primary			
	part thereof (clist separately in addition to code for primary procedure)			
483T	Transcatheter mitral valve implantation/replacement (TMVI) with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	12/31/2999
+031			9/1/2020	12/31/2999
	prosthetic valve; percutaneous approach, including transseptal	Submit for Recommended Clinical Review to avoid post-service review.		
40.4T	puncture, when performed	MD Outstander Done of drove to small a service of a service of March 10 at 10	0/4/0000	40/04/0000
484T			9/1/2020	12/31/2999
	prosthetic valve; transthoracic exposure (eg, thoracotomy,	Submit for Recommended Clinical Review to avoid post-service review.		
	transapical)			
485T	Optical coherence tomography (OCT) of middle ear, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	interpretation and report; unilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
485T	Optical coherence tomography (OCT) of middle ear, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	interpretation and report; unilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
186T	Optical coherence tomography (OCT) of middle ear, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	interpretation and report; bilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

0486T	Optical coherence tomography (OCT) of middle ear, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	interpretation and report; bilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
494T	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
495T	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
)496T	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
)507T	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
)509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)		5/15/2021	12/31/2999
)511T	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
)511T	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).		12/31/2999
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
)512T	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

0513T	Extracorporeal shock wave for integumentary wound healing,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
513T	Extracorporeal shock wave for integumentary wound healing,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	including topical application and dressing care; each additional	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	wound (List separately in addition to code for primary procedure)	Policy (CPCP).		
516T	Insertion of wireless cardiac stimulator for left ventricular pacing,	,	10/1/2019	12/31/2999
	including device interrogation and programming, and imaging	Submit for Recommended Clinical Review to avoid post-service review.		
	supervision and interpretation, when performed; electrode only			
517T	Insertion of wireless cardiac stimulator for left ventricular pacing,	· · · · · · · · · · · · · · · · · · ·	10/1/2019	12/31/2999
	including device interrogation and programming, and imaging	Submit for Recommended Clinical Review to avoid post-service review.		
	supervision and interpretation, when performed; both			
	components of pulse generator (battery and transmitter) only			
524T	Endovenous catheter directed chemical ablation with balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2019	12/31/2999
	isolation of incompetent extremity vein, open or percutaneous,	Submit for Recommended Clinical Review to avoid post-service review.		
	including all vascular access, catheter manipulation, diagnostic			
529T	imaging, imaging guidance and monitoring Interrogation device evaluation (in person) of intracardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2019	12/31/2999
0291	ischemia monitoring system with analysis, review, and report	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
37T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
007 1	blood-derived T lymphocytes for development of genetically	Submit for Recommended Clinical Review to avoid post-service review.	0/13/2023	12/31/2999
	modified autologous CAR-T cells, per day	Journal for Neconstitiended Chilical Neview to avoid post-service review.		
538T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
0001	blood-derived T lymphocytes for transportation (eg,	Submit for Recommended Clinical Review to avoid post-service review.	0/10/2020	12/01/2000
	cryopreservation, storage)			
539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	preparation of CAR-T cells for administration	Submit for Recommended Clinical Review to avoid post-service review.		
540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell		6/15/2023	12/31/2999
	administration, autologous	Submit for Recommended Clinical Review to avoid post-service review.		
544T	Transcatheter mitral valve annulus reconstruction, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
	implantation of adjustable annulus reconstruction device,	Submit for Recommended Clinical Review to avoid post-service review.		
	percutaneous approach including transseptal puncture			
545T	Transcatheter tricuspid valve annulus reconstruction with		9/1/2023	12/31/2999
	implantation of adjustable annulus reconstruction device,	Submit for Recommended Clinical Review to avoid post-service review.		
	percutaneous approach			
546T	Radiofrequency spectroscopy, real time, intraoperative margin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2024	12/31/2999
	assessment, at the time of partial mastectomy, with report	Submit for Recommended Clinical Review to avoid post-service review.	10/15/0000	40/04/2000
552T	Low-level laser therapy, dynamic photonic and dynamic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/15/2020	12/31/2999
	thermokinetic energies, provided by a physician or other	Submit for Recommended Clinical Review to avoid post-service review.		
ECT	qualified health care professional	FILL Dropoduro/com/ice not reimburoed by the Dien Net subject to	10/1/2020	10/04/0000
563T	Evacuation of meibomian glands, using heat delivered through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
563T	Evacuation of meibomian glands, using heat delivered through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
JUJ 1	wearable, open-eye eyelid treatment devices and manual gland	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
	expression, bilateral	Policy (CPCP).		

0565T	Autologous cellular implant derived from adipose tissue for the	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	treatment of osteoarthritis of the knees; tissue harvesting and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	cellular implant creation	Policy (CPCP).		
565T	Autologous cellular implant derived from adipose tissue for the	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	treatment of osteoarthritis of the knees; tissue harvesting and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	cellular implant creation	Policy (CPCP).		
566T	Autologous cellular implant derived from adipose tissue for the	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	treatment of osteoarthritis of the knees; injection of cellular	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	implant into knee joint including ultrasound guidance, unilateral	Policy (CPCP).		
)566T	Autologous cellular implant derived from adipose tissue for the	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	treatment of osteoarthritis of the knees; injection of cellular	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	implant into knee joint including ultrasound guidance, unilateral	Policy (CPCP).		
569T	Transcatheter tricuspid valve repair, percutaneous approach;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
	initial prosthesis	Submit for Recommended Clinical Review to avoid post-service review.		
)570T	Transcatheter tricuspid valve repair, percutaneous approach;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
	each additional prosthesis during same session (List separately	Submit for Recommended Clinical Review to avoid post-service review.		
	in addition to code for primary procedure)			
)587T	Percutaneous implantation or replacement of integrated single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
	device neurostimulation system for bladder dysfunction	Submit for Recommended Clinical Review to avoid post-service review.		
	including electrode array and receiver or pulse generator,			
	including analysis, programming, and imaging guidance when			
	performed, posterior tibial nerve			
)588T	Revision or removal of percutaneously placed integrated single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
	device neurostimulation system for bladder dysfunction	Submit for Recommended Clinical Review to avoid post-service review.		
	including electrode array and receiver or pulse generator,			
	including analysis, programming, and imaging guidance when			
	performed, posterior tibial nerve			
0589T	Electronic analysis with simple programming of implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
	integrated neurostimulation system for bladder dysfunction (eg,	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
)590T	Electronic analysis with complex programming of implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
	integrated neurostimulation system for bladder dysfunction (eg,	Submit for Recommended Clinical Review to avoid post-service review.		
	electrode array and receiver), including contact group(s),	<u>'</u>		
	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			
)596T	Temporary female intraurethral valve-pump (ie, voiding	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
	prosthesis); initial insertion, including urethral measurement	Submit for Recommended Clinical Review to avoid post-service review.		
)597T	Temporary female intraurethral valve-pump (ie, voiding	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
	prosthesis); replacement	Submit for Recommended Clinical Review to avoid post-service review.	1	, 5 1, 2000

0598T	Noncontact real-time fluorescence wound imaging, for bacterial	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	presence, location, and load, per session; first anatomic site	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	(eg. lower extremity)	Policy (CPCP).		
598T	Noncontact real-time fluorescence wound imaging, for bacterial	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	presence, location, and load, per session; first anatomic site	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	(eg, lower extremity)	Policy (CPCP).		
598T	Noncontact real-time fluorescence wound imaging, for bacterial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2024	9/30/2024
	presence, location, and load, per session; first anatomic site	Submit for Recommended Clinical Review to avoid post-service review.		
	(eg, lower extremity)	Custing for recommended climical review to avoid poor corrido review.		
99T	Noncontact real-time fluorescence wound imaging, for bacterial	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	presence, location, and load, per session; each additional	review. Check EIU policy, which is one of our Clinical Payment and Coding		, .,,
	anatomic site (eg, upper extremity) (List separately in addition to			
	code for primary procedure)	l olicy (of or).		
599T	Noncontact real-time fluorescence wound imaging, for bacterial	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
331	presence, location, and load, per session; each additional	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/01/2000
	anatomic site (eg, upper extremity) (List separately in addition to			
	code for primary procedure)	l olicy (of of).		
599T	Noncontact real-time fluorescence wound imaging, for bacterial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2024	9/30/2024
1991	presence, location, and load, per session; each additional	Submit for Recommended Clinical Review to avoid post-service review.	0/13/2024	9/30/2024
	anatomic site (eg, upper extremity) (List separately in addition to			
00T	code for primary procedure) Ablation, irreversible electroporation; 1 or more tumors per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
001			9/1/2023	12/31/2999
	organ, including imaging guidance, when performed,	Submit for Recommended Clinical Review to avoid post-service review.		
NO4T	percutaneous	MD Criteria: Draga dura (samilas reviewed a reinat Madical Delia) Criteria	0/4/0000	40/04/0000
601T	Ablation, irreversible electroporation; 1 or more tumors per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
	organ, including fluoroscopic and ultrasound guidance, when	Submit for Recommended Clinical Review to avoid post-service review.		
2007	performed, open	FILL Down the description of the last of the Disconnection of the Discon	4/4/0004	40/04/0000
602T	Glomerular filtration rate (GFR) measurement(s), transdermal,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
	including sensor placement and administration of a single dose	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of fluorescent pyrazine agent	Policy (CPCP).		
602T	Glomerular filtration rate (GFR) measurement(s), transdermal,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
	including sensor placement and administration of a single dose	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of fluorescent pyrazine agent	Policy (CPCP).		
603T	Glomerular filtration rate (GFR) monitoring, transdermal,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	dose of fluorescent pyrazine agent, each 24 hours	Policy (CPCP).		
603T	Glomerular filtration rate (GFR) monitoring, transdermal,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	dose of fluorescent pyrazine agent, each 24 hours	Policy (CPCP).		
615T	Eye-movement analysis without spatial calibration, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
615T	Eye-movement analysis without spatial calibration, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
619T	Cystourethroscopy with transurethral anterior prostate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	commissurotomy and drug delivery, including transrectal	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ultrasound and fluoroscopy, when performed	Policy (CPCP).		

0619T	Cystourethroscopy with transurethral anterior prostate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	commissurotomy and drug delivery, including transrectal	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	ultrasound and fluoroscopy, when performed	Policy (CPCP).		
619T	Cystourethroscopy with transurethral anterior prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
	commissurotomy and drug delivery, including transrectal	Submit for Recommended Clinical Review to avoid post-service review.		
	ultrasound and fluoroscopy, when performed	· ·		
620T	Endovascular venous arterialization, tibial or peroneal vein, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	transcatheter placement of intravascular stent graft(s) and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	closure by any method, including percutaneous or open	Policy (CPCP).		
	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			
0620T	Endovascular venous arterialization, tibial or peroneal vein, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	transcatheter placement of intravascular stent graft(s) and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	closure by any method, including percutaneous or open	Policy (CPCP).		
	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			
621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	-	Policy (CPCP).	11110001	10/01/0000
)621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	Tools and a standard by the man but to a small the standard by	Policy (CPCP).	4/4/0004	40/04/0000
)622T	Trabeculostomy ab interno by laser; with use of ophthalmic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	endoscope	review. Check EIU policy, which is one of our Clinical Payment and Coding		
)622T	Trah aculastamy ab interna by lacer, with use of anhthalmic	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
10221	Trabeculostomy ab interno by laser; with use of ophthalmic		1/ 1/2021	12/31/2999
	endoscope	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
)623T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
10231	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding	1/ 1/2021	12/31/2999
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	data preparation and transmission, computerized analysis of	Folicy (GFGF).		
	data, with review of computerized analysis output to reconcile			
	discordant data, interpretation and report			
623T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		12,0.,2000
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	data preparation and transmission, computerized analysis of	/ (/-		
	data, with review of computerized analysis output to reconcile			
	discordant data, interpretation and report			
624T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	data preparation and transmission			

0624T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	data preparation and transmission			
625T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	computerized analysis of data from coronary computed			
	tomographic angiography			
625T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	computerized analysis of data from coronary computed			
	tomographic angiography			
)626T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	review of computerized analysis output to reconcile discordant			
	data, interpretation and report			
626T	Automated quantification and characterization of coronary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	atherosclerotic plaque to assess severity of coronary disease,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	using data from coronary computed tomographic angiography;	Policy (CPCP).		
	review of computerized analysis output to reconcile discordant			
	data, interpretation and report			
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based		1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic guidance, lumbar; first level	Policy (CPCP).		
627T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic guidance, lumbar; first level	Policy (CPCP).		
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based		1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic guidance, lumbar; each additional level (List	Policy (CPCP).		
000T	separately in addition to code for primary procedure)		4/4/0004	40/04/0000
628T	Percutaneous injection of allogeneic cellular and/or tissue-based		1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fluoroscopic guidance, lumbar; each additional level (List	Policy (CPCP).		
	separately in addition to code for primary procedure)	I Citt Door door to make a starting house of houth a Diagram of the starting house of th	4/4/0004	40/04/0000
629T	Percutaneous injection of allogeneic cellular and/or tissue-based		1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
2007	CT guidance, lumbar; first level	Policy (CPCP).	4/4/0004	40/04/0000
629T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
COOT	CT guidance, lumbar; first level	Policy (CPCP).	4/4/0004	40/04/0000
630T	Percutaneous injection of allogeneic cellular and/or tissue-based		1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CT guidance, lumbar; each additional level (List separately in	Policy (CPCP).		
	addition to code for primary procedure)			

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

0651T	Magnetically controlled capsule endoscopy, esophagus through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	stomach, including intraprocedural positioning of capsule, with	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0651T	interpretation and report Magnetically controlled capsule endoscopy, esophagus through	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2022	12/31/2999
00311	stomach, including intraprocedural positioning of capsule, with	review. Check EIU policy, which is one of our Clinical Payment and Coding	1/1/2023	12/31/2999
	interpretation and report	Policy (CPCP).		
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2021	12/31/2999
	7 vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0656T	Antorior lumbar or thorosolumbar vertebral body tethering: up to	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2021	12/31/2999
00001	7 vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding	11 112021	12/31/2999
	7 Vertebrai Segitienits	Policy (CPCP).		
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2021	12/31/2999
	more vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2021	12/31/2999
	more vertebral segments	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0664T	Donor hysterectomy (including cold preservation); open, from	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	cadaver donor	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0664T	Donor hysterectomy (including cold preservation); open, from	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	cadaver donor	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0665T	Donor hysterectomy (including cold preservation); open, from	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0665T	Donor hysterectomy (including cold preservation); open, from	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0666T	Donor hysterectomy (including cold preservation); laparoscopic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	or robotic, from living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 10, 202 1	12/01/2000
	or research manning deriver	Policy (CPCP).		
0666T	Donor hysterectomy (including cold preservation); laparoscopic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	or robotic, from living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0667T	Donor hysterectomy (including cold preservation); recipient	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	uterus allograft transplantation from cadaver or living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0667T	Donor hysterectomy (including cold preservation); recipient	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	uterus allograft transplantation from cadaver or living donor	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0668T	Backbench standard preparation of cadaver or living donor	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/15/2021	12/31/2999
00001		review. Check EIU policy, which is one of our Clinical Payment and Coding	0/13/2021	12/3/1/233
	removal of surrounding soft tissues and preparation of uterine	Policy (CPCP).		
	vein(s) and uterine artery(ies), as necessary	olicy (Or Or).		
0668T	Backbench standard preparation of cadaver or living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	· ·	review. Check EIU policy, which is one of our Clinical Payment and Coding	1. 10,2021	.2,0,,2000
	removal of surrounding soft tissues and preparation of uterine	Policy (CPCP).		
	vein(s) and uterine artery(ies), as necessary	, ,		

0669T	Dealthanab reconstruction of endover or living denor utarus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/45/2024	12/31/2999
00091	Backbench reconstruction of cadaver or living donor uterus		8/15/2021	12/31/2999
	allograft prior to transplantation; venous anastomosis, each	review. Check EIU policy, which is one of our Clinical Payment and Coding		
OCCOT.	Dealth and by a construction of an deven on living demands on a	Policy (CPCP).	0/45/0004	40/04/0000
0669T	Backbench reconstruction of cadaver or living donor uterus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	allograft prior to transplantation; venous anastomosis, each	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0070T	Dealth and by a construction of an deven on living demands on a	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/45/0004	40/04/0000
0670T	Backbench reconstruction of cadaver or living donor uterus		8/15/2021	12/31/2999
	allograft prior to transplantation; arterial anastomosis, each	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0670T	Backbench reconstruction of cadaver or living donor uterus	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/45/2024	12/31/2999
10701			0/ 13/2021	12/31/2999
	allograft prior to transplantation; arterial anastomosis, each	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
)672T	Endovaginal cryogen-cooled, monopolar radiofrequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	remodeling of the tissues surrounding the female bladder neck	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and proximal urethra for urinary incontinence	Policy (CPCP).		
)672T	Endovaginal cryogen-cooled, monopolar radiofrequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	remodeling of the tissues surrounding the female bladder neck	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	and proximal urethra for urinary incontinence	Policy (CPCP).		
692T	Therapeutic ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
720T	Percutaneous electrical nerve field stimulation, cranial nerves,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2024	12/31/2999
	without implantation	Submit for Recommended Clinical Review to avoid post-service review.		
740T	Remote autonomous algorithm-based recommendation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
	for insulin dose calculation and titration; initial set-up and patient	Submit for Recommended Clinical Review to avoid post-service review.		
	education			
)741T	Remote autonomous algorithm-based recommendation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2023	12/31/2999
	for insulin dose calculation and titration; provision of software,	Submit for Recommended Clinical Review to avoid post-service review.		
	data collection, transmission, and storage, each 30 days			
743T	Bone strength and fracture risk using finite element analysis of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	functional data and bone mineral density (BMD), with concurrent	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	vertebral fracture assessment, utilizing data from a computed	Policy (CPCP).		
	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			
743T	Bone strength and fracture risk using finite element analysis of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	functional data and bone mineral density (BMD), with concurrent	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	vertebral fracture assessment, utilizing data from a computed	Policy (CPCP).		
	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			
744T	Insertion of bioprosthetic valve, open, femoral vein, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	autogenous or nonautogenous patch graft (eg, polyester,	Policy (CPCP).		
	ePTFE, bovine pericardium), when performed			
744T	Insertion of bioprosthetic valve, open, femoral vein, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	duplex ultrasound imaging guidance, when performed, including	· · · · · · · · · · · · · · · · · · ·		
	autogenous or nonautogenous patch graft (eg, polyester,	Policy (CPCP).		

)745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	noninvasive arrhythmia localization and mapping of arrhythmia	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
'46T	Cardiac focal ablation utilizing radiation therapy for arrhythmia;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	• • • • • • • • • • • • • • • • • • • •	Submit for Recommended Clinical Review to avoid post-service review.		
	site (nidus) into a multidimensional radiation treatment plan	'		
'47T	Cardiac focal ablation utilizing radiation therapy for arrhythmia;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	delivery of radiation therapy, arrhythmia	Submit for Recommended Clinical Review to avoid post-service review.		
'48T	Injections of stem cell product into perianal perifistular soft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	tissue, including fistula preparation (eg, removal of setons,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fistula curettage, closure of internal openings)	Policy (CPCP).		
48T	Injections of stem cell product into perianal perifistular soft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	tissue, including fistula preparation (eg, removal of setons,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	fistula curettage, closure of internal openings)	Policy (CPCP).		
'64T	Assistive algorithmic electrocardiogram risk-based assessment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	for cardiac dysfunction (eg, low-ejection fraction, pulmonary	Submit for Recommended Clinical Review to avoid post-service review.		
	hypertension, hypertrophic cardiomyopathy); related to			
	concurrently performed electrocardiogram (List separately in			
	addition to code for primary procedure)			
65T	Assistive algorithmic electrocardiogram risk-based assessment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2023	12/31/2999
	for cardiac dysfunction (eg, low-ejection fraction, pulmonary	Submit for Recommended Clinical Review to avoid post-service review.		
	hypertension, hypertrophic cardiomyopathy); related to	·		
	previously performed electrocardiogram			
66T	Transcutaneous magnetic stimulation by focused low-frequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	marking of the treatment location, including noninvasive	Policy (CPCP).		
	electroneurographic localization (nerve conduction localization),			
	when performed; first nerve			
766T	Transcutaneous magnetic stimulation by focused low-frequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	marking of the treatment location, including noninvasive	Policy (CPCP).		
	electroneurographic localization (nerve conduction localization),			
	when performed; first nerve			
67T	Transcutaneous magnetic stimulation by focused low-frequency		7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	marking of the treatment location, including noninvasive	Policy (CPCP).		
	electroneurographic localization (nerve conduction localization),			
	when performed; each additional nerve (List separately in			
	addition to code for primary procedure)			
67T	Transcutaneous magnetic stimulation by focused low-frequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	marking of the treatment location, including noninvasive	Policy (CPCP).		
	electroneurographic localization (nerve conduction localization),			
	when performed; each additional nerve (List separately in			
	addition to code for primary procedure)			
770T	Virtual reality technology to assist therapy (List separately in	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	,	Policy (CPCP).		

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	9/1/2023	12/31/2999
	addition to code for primary procedure)	Policy (CPCP).		
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	EIU: Procedure/service not 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	physiological status; initial 15 minutes of intraservice time, patient age 5 years or older 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	EIU: Procedure/service not 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
	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			
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	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).		12/31/2999
0773Т	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older		9/1/2023	12/31/2999

0774T	Virtual reality (VR) procedural dissociation services provided by	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	a physician or other qualified health care professional other than the physician or other qualified health care professional	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
	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)			
)774T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	The state of the s	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	the physician or other qualified health care professional	Policy (CPCP).		
	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)			
)776T	Therapeutic induction of intra-brain hypothermia, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	placement of a mechanical temperature-controlled cooling	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	device to the neck over carotids and head, including monitoring	Policy (CPCP).		
	(eg, vital signs and sport concussion assessment tool 5			
	[SCAT5]), 30 minutes of treatment			
)776T	Therapeutic induction of intra-brain hypothermia, including	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	placement of a mechanical temperature-controlled cooling	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	device to the neck over carotids and head, including monitoring	Policy (CPCP).		
	(eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment			
)777T	Real-time pressure-sensing epidural guidance system (List	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding	07.172020	.2,0.,2000
		Policy (CPCP).		
0777T	Real-time pressure-sensing epidural guidance system (List	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0778T	Surface mechanomyography (sMMG) with concurrent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	application of inertial measurement unit (IMU) sensors for	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	measurement of multi-joint range of motion, posture, gait, and muscle function	Policy (CPCP).		
)778T	Surface mechanomyography (sMMG) with concurrent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	application of inertial measurement unit (IMU) sensors for	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	measurement of multi-joint range of motion, posture, gait, and	Policy (CPCP).		
	muscle function			
)779T	Gastrointestinal myoelectrical activity study, stomach through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	colon, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding		
7707		Policy (CPCP).	0/4/0000	40/04/0000
)779T	Gastrointestinal myoelectrical activity study, stomach through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	colon, with interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
780T	Instillation of fecal microbiota suspension via rectal enema into	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2023	12/31/2999
501	lower gastrointestinal tract	Submit for Recommended Clinical Review to avoid post-service review.		12/01/2000
781T	Bronchoscopy, rigid or flexible, with insertion of esophageal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	protection device and circumferential radiofrequency destruction	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of the pulmonary nerves, including fluoroscopic guidance when	Policy (CPCP).		
	performed; bilateral mainstem bronchi			

0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	protection device and circumferential radiofrequency destruction	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of the pulmonary nerves, including fluoroscopic guidance when	Policy (CPCP).		
	performed; bilateral mainstem bronchi			
782T	Bronchoscopy, rigid or flexible, with insertion of esophageal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	protection device and circumferential radiofrequency destruction	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of the pulmonary nerves, including fluoroscopic guidance when	Policy (CPCP).		
	performed; unilateral mainstem bronchus			
)782T	Bronchoscopy, rigid or flexible, with insertion of esophageal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	protection device and circumferential radiofrequency destruction	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	of the pulmonary nerves, including fluoroscopic guidance when	Policy (CPCP).		
	performed; unilateral mainstem bronchus			
0783T	Transcutaneous auricular neurostimulation, set-up, calibration,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	and patient education on use of equipment	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
783T	Transcutaneous auricular neurostimulation, set-up, calibration,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	and patient education on use of equipment	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
)784T	Insertion or replacement of percutaneous electrode array,	, ,	3/15/2024	12/31/2999
	spinal, with integrated neurostimulator, including imaging	Submit for Recommended Clinical Review to avoid post-service review.		
	guidance, when performed			
785T	Revision or removal of neurostimulator electrode array, spinal,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	with integrated neurostimulator	Submit for Recommended Clinical Review to avoid post-service review.		
786T	Insertion or replacement of percutaneous electrode array,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	sacral, with integrated neurostimulator, including imaging	Submit for Recommended Clinical Review to avoid post-service review.		
	guidance, when performed			
)787T	Revision or removal of neurostimulator electrode array, sacral,	, ,	3/15/2024	12/31/2999
	with integrated neurostimulator	Submit for Recommended Clinical Review to avoid post-service review.		
788T	Electronic analysis with simple programming of implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	integrated neurostimulation system (eg, electrode array and	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
789T	Electronic analysis with complex programming of implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	integrated neurostimulation system (eg, electrode array and	Submit for Recommended Clinical Review to avoid post-service review.		
	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			
790T	Revision (eg, augmentation, division of tether), replacement, or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	removal of thoracolumbar or lumbar vertebral body tethering,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including thoracoscopy, when performed	Policy (CPCP).		
790T	Revision (eg, augmentation, division of tether), replacement, or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	removal of thoracolumbar or lumbar vertebral body tethering,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including thoracoscopy, when performed	Policy (CPCP).		

0790T	Revision (eg, augmentation, division of tether), replacement, or	, , , , , , , , , , , , , , , , , , , ,	2/15/2024	5/14/2024
	removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	Submit for Recommended Clinical Review to avoid post-service review.		
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	training, each 15 minutes (List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	training, each 15 minutes (List separately in addition to code for	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	primary procedure)	Policy (CPCP).		
)793T	Percutaneous transcatheter thermal ablation of nerves	l	7/1/2023	12/31/2999
	innervating the pulmonary arteries, including right heart	Submit for Recommended Clinical Review to avoid post-service review.		
	catheterization, pulmonary artery angiography, and all imaging			
7057	guidance	ND O '' : D	7/4/0000	10/04/0000
0795T	Transcatheter insertion of permanent dual-chamber leadless	,	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
)796T	Transcatheter insertion of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
.,	pacemaker, including imaging guidance (eg, fluoroscopy,	Submit for Recommended Clinical Review to avoid post-service review.	17 172020	12/01/2000
	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)			
)797T	Transcatheter insertion of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy,	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			101011000
)798T	Transcatheter removal of permanent dual-chamber leadless	,	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy,	Submit for Recommended Clinical Review to avoid post-service review.		
	venous ultrasound, right atrial angiography, right			
	ventriculography, femoral venography), when performed;			
	complete system (ie, right atrial and right ventricular pacemaker			
799T	components) Transcatheter removal of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy,	Submit for Recommended Clinical Review to avoid post-service review.	17.72020	12/01/2000
	venous ultrasound, right atrial angiography, right	Capital 101 1 to contain and a capital to the avoid pool con vice to view.		
	ventriculography, femoral venography), when performed; right			
	atrial pacemaker component			

0800Т	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)		7/1/2023	12/31/2999
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

T8080	Pulmonary tissue ventilation analysis using software-based	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	processing of data from separately captured cinefluorograph	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	images; in combination with computed tomography (CT) images	Policy (CPCP).		
	taken for the purpose of pulmonary tissue ventilation analysis,			
	including data preparation and transmission, quantification of			
	pulmonary tissue ventilation, data review, interpretation and			
	report			
808T	Pulmonary tissue ventilation analysis using software-based	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2023	12/31/2999
	processing of data from separately captured cinefluorograph	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	images; in combination with computed tomography (CT) images	Policy (CPCP).		
	taken for the purpose of pulmonary tissue ventilation analysis,			
	including data preparation and transmission, quantification of			
	pulmonary tissue ventilation, data review, interpretation and			
	report		=///C000	10/01/0000
810T	Subretinal injection of a pharmacologic agent, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
044T	vitrectomy and 1 or more retinotomies	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
811T	Remote multi-day complex uroflowmetry (eg, calibrated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2024	12/31/2999
	electronic equipment); set-up and patient education on use of	service review.		
010T	equipment Remote multi-day complex uroflowmetry (eg, calibrated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2024	12/21/2000
812T	electronic equipment); device supply with automated report	· · · · · · · · · · · · · · · · · · ·	1/1/2024	12/31/2999
		service review.		
313T	generation, up to 10 days Esophagogastroduodenoscopy, flexible, transoral, with volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
0101	adjustment of intragastric bariatric balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding	77172024	12/31/2999
	adjustifient of intragastric bariatric balloon	Policy (CPCP).		
813T	Esophagogastroduodenoscopy, flexible, transoral, with volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
0101	adjustment of intragastric bariatric balloon	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 172024	12/01/2000
	adjustment of intragastrio banderi	Policy (CPCP).		
813T	Esophagogastroduodenoscopy, flexible, transoral, with volume	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	6/30/2024
	adjustment of intragastric bariatric balloon	Submit for Recommended Clinical Review to avoid post-service review.		
816T	Open insertion or replacement of integrated neurostimulation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	system for bladder dysfunction including electrode(s) (eg, array	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	or leadless), and pulse generator or receiver, including analysis,	Policy (CPCP).		
	programming, and imaging guidance, when performed, posterior			
	tibial nerve; subcutaneous			
316T	Open insertion or replacement of integrated neurostimulation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	system for bladder dysfunction including electrode(s) (eg, array	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	or leadless), and pulse generator or receiver, including analysis,	Policy (CPCP).		
	programming, and imaging guidance, when performed, posterior			
	tibial nerve; subcutaneous			
316T	Open insertion or replacement of integrated neurostimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2024	6/30/2024
	system for bladder dysfunction including electrode(s) (eg, array	Submit for Recommended Clinical Review to avoid post-service review.		
	or leadless), and pulse generator or receiver, including analysis,			
	programming, and imaging guidance, when performed, posterior			
0407	tibial nerve; subcutaneous	FILL December (complete metasischem et bestellt blee Diese Network)	7/4/0004	40/04/0000
318T	Revision or removal of integrated neurostimulation system for	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	bladder dysfunction, including analysis, programming, and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	imaging, when performed, posterior tibial nerve; subcutaneous	Policy (CPCP).		

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

0864T	Low-intensity extracorporeal shock wave therapy involving	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	corpus cavernosum, low energy	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
)864T	Low-intensity extracorporeal shock wave therapy involving	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	6/30/2024
	corpus cavernosum, low energy	Submit for Recommended Clinical Review to avoid post-service review.		
870T	Implantation of subcutaneous peritoneal ascites pump system,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
	percutaneous, including pump-pocket creation, insertion of	Submit for Recommended Clinical Review to avoid post-service review.		
	tunneled indwelling bladder and peritoneal catheters with pump	'		
	connections, including all imaging and initial programming, when			
	performed			
871T	Replacement of a subcutaneous peritoneal ascites pump,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
	including reconnection between pump and indwelling bladder	Submit for Recommended Clinical Review to avoid post-service review.	07.7202.	12/01/2000
	and peritoneal catheters, including initial programming and	Custilities (Coolimonada Cilinoai (Colow to avoia post service review.		
	imaging, when performed			
372T	Replacement of indwelling bladder and peritoneal catheters,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
)/ 2	including tunneling of catheter(s) and connection with previously	l	9/1/2024	12/3/1/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	implanted peritoneal ascites pump, including imaging and			
70T	programming, when performed	ND Oritoria - David de la constanta de la cons	0/4/0004	40/04/0000
373T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
	system, any component (ascites pump, associated peritoneal	Submit for Recommended Clinical Review to avoid post-service review.		
	catheter, associated bladder catheter), including imaging and			
	programming, when performed			
374T	Removal of a peritoneal ascites pump system, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
	implanted peritoneal ascites pump and indwelling bladder and	Submit for Recommended Clinical Review to avoid post-service review.		
	peritoneal catheters			
375T	Programming of subcutaneously implanted peritoneal ascites	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2024	12/31/2999
	pump system by physician or other qualified health care	Submit for Recommended Clinical Review to avoid post-service review.		
	professional	·		
389T	Personalized target development for accelerated, repetitive high-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	dose functional connectivity MRI-guided theta-burst stimulation	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	derived from a structural and resting-state functional MRI,	Policy (CPCP).		
	including data preparation and transmission, generation of the			
	target, motor threshold-starting location, neuronavigation files			
	and target report, review and interpretation			
390T	Accelerated, repetitive high-dose functional connectivity MRI-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
1001	guided theta-burst stimulation, including target assessment,	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/31/2999
	initial motor threshold determination, neuronavigation, delivery	Policy (CPCP).		
)O4T	and management, initial treatment day	FILL Door door to make a standard by the Dien Net subject to make a single	40/4/0004	40/04/0000
391T	Accelerated, repetitive high-dose functional connectivity MRI-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	guided theta-burst stimulation, including neuronavigation,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	delivery and management, subsequent treatment day	Policy (CPCP).		
92T	Accelerated, repetitive high-dose functional connectivity MRI-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	guided theta-burst stimulation, including neuronavigation,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	delivery and management, subsequent motor threshold	Policy (CPCP).		
	redetermination with delivery and management, per treatment			
	day			
701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
SIUIA		service review.		
10004				
0021	Ambulance service, outside state per mile, transport (medicaid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999

A0080	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.	1/1/2021	12/31/2999
A0100	Non-emergency transportation; taxi		1/1/2021	12/31/2999
A0110	Non-emergency transportation and bus, intra or inter state carrier		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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.		12/31/2999
A0190	Non-emergency transportation: ancillary: meals-recipient	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		12/31/2999
A0200	Non-emergency transportation: ancillary: lodging escort	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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)		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

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	1/1/2025	12/31/2999
40000		code is managed by Alacura.	4/4/0005	10/04/0000
A0398	ALS routine disposable supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review. This		
A 0 4 0 0	Analysis and the second state of the second st	code is managed by Alacura.	1/1/2025	40/04/0000
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	increments	Submit for Recommended Clinical Review to avoid post-service review. This		
40400		code is managed by Alacura.	4/4/0005	40/04/0000
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	sustaining situation	Submit for Recommended Clinical Review to avoid post-service review. This		
10101		code is managed by Alacura.	4/4/0005	40/04/0000
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or		1/1/2025	12/31/2999
	rotary winged); (requires medical review)	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0425	Ground mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0426	Ambulance service, advanced life support, non-emergency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2014	12/31/2999
	transport, level 1 (als 1)	Submit for Recommended Clinical Review to avoid post-service review.		
A0426	Ambulance service, advanced life support, non-emergency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	transport, Level 1 (ALS1)	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0427	Ambulance service, advanced life support, emergency transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	Level 1 (ALS1-Emergency)	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0428	Ambulance service, basic life support, non-emergency transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	(BLS)	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0429	Ambulance service, basic life support, emergency transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	(BLS-Emergency)	Submit for Recommended Clinical Review to avoid post-service review. This		
	, , ,	code is managed by Alacura.		
A0431	Ambulance service, conventional air services, transport, one	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2007	12/31/2999
	way (rotary wing)	Submit for Recommended Clinical Review to avoid post-service review.		
A0431	Ambulance service, conventional air services, transport, one	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	way (rotary wing)	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0432	Paramedic intercept (PI), rural area, transport furnished by a	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	volunteer ambulance company which is prohibited by state law	Submit for Recommended Clinical Review to avoid post-service review. This		
	from billing third party payers	code is managed by Alacura.		
A0433	Advanced life support, Level 2 (ALS2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
	- 1	Submit for Recommended Clinical Review to avoid post-service review. This	17 172020	12/01/2000
		code is managed by Alacura.		
A0434	Specialty care transport (SCT)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/2999
710-10-1	openially date transport (001)	Submit for Recommended Clinical Review to avoid post-service review. This	1/1/2023	12/01/2000
		code is managed by Alacura.		
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
A0430	Trotary wing an inneage, per statute inne	Submit for Recommended Clinical Review to avoid post-service review.	1/1/1830	1213112333
		Submit for Neconfinenced Chilical Neview to avoid post-service review.		

A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/299
	3 71	Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0888	Noncovered ambulance mileage, per mile (e. G., for miles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
	traveled beyond closest appropriate facility)	service review.		
A0998	Ambulance response and treatment, no transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2025	12/31/299
		Submit for Recommended Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	444540000	10/01/0000
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
4.0000	No. 100 Alexandra and 100 Alex	Policy (CPCP).	4/45/0000	40/04/0000
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
A 2007	Doctorto in on oniversi continuatori	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/45/0000	40/04/0000
A2007	Restrata, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	4/15/2022	12/31/2999
		Policy (CPCP).		
A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/45/2022	12/31/2999
A2001	Restrata, per square certimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	4/13/2022	12/31/2999
		Policy (CPCP).		
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
A2000	Thoragenesis, per square certuineter	review. Check EIU policy, which is one of our Clinical Payment and Coding	7/10/2022	12/3/1/233
		Policy (CPCP).		
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
A2000	Thoragenesis, per square certuineter		7/10/2022	12/3/1/233
		•		
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		

A2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2012	Suprathel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	0///0000	10/01/0000
A2012	Suprathel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
10040	I a second delication of the second s	Policy (CPCP).	0/4/0000	40/04/0000
A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
A2013	Innovamatrix fs, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/2022	12/31/2999
12013	innovamatrix is, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2022	12/31/2999
		Policy (CPCP).		
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
12014	Officea collager matrix, per 100 mg	review. Check EIU policy, which is one of our Clinical Payment and Coding	7/1/2020	12/01/2000
		Policy (CPCP).		
\2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
.2011	omoza osnagon mann, per 100 mg	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172020	12/01/2000
		Policy (CPCP).		
2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
	• •	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	2///222	1.010.110.00
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
10000	A - F - d d d (F)	Policy (CPCP).	0/4/0000	40/04/0000
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
\2020	Ac5 advanced wound system (ac5)	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/2022	12/31/2999
12020	Aco advanced wound system (aco)	review. Check EIU policy, which is one of our Clinical Payment and Coding	9/1/2023	12/31/2999
		Policy (CPCP).		
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
12021	recomatine, per square continueter	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 1/2023	12/01/2000
		Policy (CPCP).		
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	, 1	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0004	D	Policy (CPCP).	40/4/0000	40/04/0000
12024	Resolve matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
12024	Decelve metrix or venenately nor equare equition of a	Policy (CPCP).	10/1/2022	12/31/2999
A2024	Resolve matrix or xenopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

A2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	- 71	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	- 71	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
	, •	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
	·	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
A4244	Alcohol or peroxide, per pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4246	Betadine or phisohex solution, per pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4247	Betadine or iodine swabs/wipes, per box	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4335	Incontinence supply; miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4341	Indwelling intraurethral drainage device with valve, patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
	inserted, replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
A4342	Accessories for patient inserted indwelling intraurethral drainage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
	device with valve, replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
A4450	Tape, non-waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4452	Tape, waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4458	Enema bag with tubing, reusable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4465	Non-elastic binder for extremity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4490	Surgical stockings above knee length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A4495	Surgical stockings thigh length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.	4444050	10/01/0000
A4500	Surgical stockings below knee length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
A 4540		service review.	4/4/4050	10/04/0000
A4510	Surgical stockings full length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
A 4500	INCONTINUENCE CARMENT ANY TYPE /E O PRIES	service review.	1/1/2005	10/21/2000
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF,	, , , , , , , , , , , , , , , , , , , ,	1/1/2005	12/31/2999
A 4540	DIAPER), EACH	service review.	E/4E/2024	10/21/2000
A4540	Distal transcutaneous electrical nerve stimulator, stimulates	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	peripheral nerves of the upper arm	review. Check EIU policy, which is one of our Clinical Payment and Coding		
A 4 E 4 O	Distal transcutonosus electrical news etimulates -timulates	Policy (CPCP).	E/4E/2024	12/31/2999
A4540	Distal transcutaneous electrical nerve stimulator, stimulates	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	peripheral nerves of the upper arm	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

A4540	Distal transcutaneous electrical nerve stimulator, stimulates	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	peripheral nerves of the upper arm	Submit for Recommended Clinical Review to avoid post-service review.		
44541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
4542	Supplies and accessories for external upper limb tremor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	stimulator of the peripheral nerves of the wrist	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	' '	Policy (CPCP).		
\4542	Supplies and accessories for external upper limb tremor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	stimulator of the peripheral nerves of the wrist	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4542	Supplies and accessories for external upper limb tremor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
	stimulator of the peripheral nerves of the wrist	Submit for Recommended Clinical Review to avoid post-service review.	_, ,	0, 1 1, 202 1
4554	Disposable underpads, all sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
11001	Dioposable anasipaas, an sizes	service review.	17 17 1000	12/01/2000
4555	Electrode/transducer for use with electrical stimulation device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2017	12/31/2999
4333	used for cancer treatment, replacement only	Submit for Recommended Clinical Review to avoid post-service review.	0/13/2017	12/31/2999
\4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
4330	ELECTRICAL DEVICE (E.G., TENS, NMES), PER OZ	service review.	1/1/1930	12/31/2999
4560		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/15/2024	12/31/2999
4300	Neuromuscular electrical stimulator (nmes), disposable,	· · · · · · · · · · · · · · · · · · ·	1/15/2024	12/31/2999
	replacement only	review. Check EIU policy, which is one of our Clinical Payment and Coding		
1500		Policy (CPCP).	4/45/0004	40/04/0000
4560	Neuromuscular electrical stimulator (nmes), disposable,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/15/2024	12/31/2999
	replacement only	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4560	Neuromuscular electrical stimulator (nmes), disposable,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2023	1/14/2024
	replacement only	Submit for Recommended Clinical Review to avoid post-service review.		
4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4596	Cranial electrotherapy stimulation (ces) system supplies and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
	accessories, per month	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	, i	Policy (CPCP).		
4596	Cranial electrotherapy stimulation (ces) system supplies and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2023	12/31/2999
	accessories, per month	review. Check EIU policy, which is one of our Clinical Payment and Coding		12,01,200
	accessories, per menur	Policy (CPCP).		
4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
	DEVICE, REPLACEMENT ONLY, EACH	Submit for Recommended Clinical Review to avoid post-service review.	., .,	12/01/2000
4638	Replacement battery for patient-owned ear pulse generator,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
	each	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2024	12/01/2000
4639	Replacement pad for infrared heating pad system, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
1-1000	Tropiacoment pad for initiated fleating pad system, each	review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 1/2020	12/01/2000
		Policy (CPCP).		
4639	Depleasment and for infrared heating and eveters as a	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/2020	12/31/2999
4039	Replacement pad for infrared heating pad system, each		9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
1000		Policy (CPCP).	4/4/40==	10/04/2222
4890	Contracts, repair and maintenance, for hemodialysis equipment		1/1/1950	12/31/2999
		service review.		

A4927	Gloves, non-sterile, per 100	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.	1/1/1950	12/31/2999
A4932		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		12/31/2999
A6000	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
46000	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 preservice review.	1/1/1950	12/31/2999
A6217		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A6218		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice review.	1/1/2006	12/31/2999
A6533		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2006	12/31/2999
A7049		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A7049		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
A9150		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A9152	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	1/1/2005	12/31/2999

A9153	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2005	12/31/2999
	TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	service review.		
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.		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).		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).		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 preservice 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 preservice review.	1/1/2005	12/31/2999
B4104	ADDITIVÉ FOR ENTERAL FORMULA (E.G. FIBER)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice review.	1/1/1950	12/31/2999

B4154	Enteral formula, nutritionally complete, for special metabolic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2013	12/31/2999
D4134	needs, excludes inherited disease of metabolism, includes	service review.	1/1/2013	12/3/1/2999
	altered composition of proteins, fats, carbohydrates, vitamins	iscivice review.		
	and/or minerals, may include fiber, administered through an			
	enteral feeding tube, 100 calories = 1 unit			
B4158	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2005	12/31/2999
D+100	COMPLETE WITH INTACT NUTRIENTS, INCLUDES	Iservice review.	17 172000	12/01/2000
	PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND	Scribe leview.		
	MINERALS, MAY INCLUDE FIBER AND/OR IRON,			
	ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE.			
B4159	100 CALORIES = 1 UNIT ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2005	12/31/2999
D4138	COMPLETE SOY BASED WITH INTACT NUTRIENTS.	Iservice review.	1/1/2003	12/31/2999
	· · · · · · · · · · · · · · · · · · ·			
	INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS			
	AND MINERALS, MAY INCLUDE FIBER AND/OR IRON,			
	ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE,			
D4400	100 CALORIES = 1 UNIT	Non-Covered Dress dure /or miles not sovered by the Dien. Not subject to me	4/4/0005	40/04/0000
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2005	12/31/2999
	COMPLETE CALORICALLY DENSE (EQUAL TO OR	service review.		
	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 =			
D 4404	1 UNIT		4/4/4050	10/01/0000
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
04050	less (500 ml = 1 unit) - homemix	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	E/4E/0004	40/04/0000
C1052	Hemostatic agent, gastrointestinal, topical		5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
04050	11	Policy (CPCP).	E/4E/0004	40/04/0000
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
04000		Policy (CPCP).	0/45/0004	10/01/0000
C1062	Intravertebral body fracture augmentation with implant (e.g.,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
0.100=	metal, polymer)	Submit for Recommended Clinical Review to avoid post-service review.		10/01/0000
C1605	Pacemaker, leadless, dual chamber (right atrial and right	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
	ventricular implantable components), rate-responsive, including	Submit for Recommended Clinical Review to avoid post-service review.		
0.1=0.1	all necessary components for implantation			10/01/0000
C1761	Catheter, transluminal intravascular lithotripsy, coronary		7/1/2021	12/31/2999
04704	F	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
C1764	Event recorder, cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
04770	I should be dead on the black	Submit for Recommended Clinical Review to avoid post-service review.	0/4/0047	40/04/0000
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2017	12/31/2999
0.1==0		Submit for Recommended Clinical Review to avoid post-service review.	0/45/005:	10/01/2222
C1778	Lead, neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		12/2/17
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2015	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
C1817	Septal defect imp sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/15/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
51010	integrated keratoprostriesis	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
C1820	Generator, neurostimulator (implantable), with rechargeable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2023	12/31/2999
71020	battery and charging system	Submit for Recommended Clinical Review to avoid post-service review.	1713/2023	12/01/2000
:1822	7 007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
1022	rechargeable battery and charging system	Submit for Recommended Clinical Review to avoid post-service review.	17 172022	12/01/2000
1823		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
71020		review. Check EIU policy, which is one of our Clinical Payment and Coding		12/01/2000
		Policy (CPCP).		
1823		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
1020		review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172022	12/01/2000
		Policy (CPCP).		
1824		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
1825	Generator, neurostimulator (implantable), non-rechargeable with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2021	12/31/2999
	carotid sinus baroreceptor stimulation lead(s)	Submit for Recommended Clinical Review to avoid post-service review.		
1826		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
-	feedback loop leads and all implantable components, with	Submit for Recommended Clinical Review to avoid post-service review.		
	rechargeable battery and charging system			
1827		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1 - 7 - 11 - 1 - 1
	·	Policy (CPCP).		
1827		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	controller	Policy (CPCP).		
1832		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
	and all system components	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	· ·	Policy (CPCP).		
1832	Autograft suspension, including cell processing and application,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1832	Autograft suspension, including cell processing and application,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2024	5/14/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
1833	Monitor, cardiac, including intracardiac lead and all system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
	components (implantable)	Submit for Recommended Clinical Review to avoid post-service review.		
2623	Catheter, transluminal angioplasty, drug-coated, non-laser	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2016	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2624	Implantable wireless pulmonary artery pressure sensor with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/16/2019	12/31/2999
	delivery catheter, including all system components	Submit for Recommended Clinical Review to avoid post-service review.		
5271		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	wound surface area	'		
5272		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	cm wound surface area, or part thereof (list separately in	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
	addition to code for primary procedure)			
5273		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
· - · · -	•	Submit for Recommended Clinical Review to avoid post-service review.		1 -,
	first 100 sq cm wound surface area, or 1% of body area of			
	misi 100 so chi woung sunace area or 1% or booy area or			

C5274	Application of low cost skin substitute graft to trunk, arms, legs,		4/1/2023	12/31/2999
	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	Submit for Recommended Clinical Review to avoid post-service review.		
	procedure)			
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		5/1/2024	3/31/2024
C9168	Injection, mirikizumab-mrkz, 1 mg		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).		12/31/2999
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).		12/31/2999
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

C9358	Dermal substitute, native, non-denatured collagen, fetal bovine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9360	Dermal substitute, native, non-denatured collagen, neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	bovine origin (SurgiMend Collagen Matrix), per 0.5 square	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	centimeters	Policy (CPCP).		
9360	Dermal substitute, native, non-denatured collagen, neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	bovine origin (SurgiMend Collagen Matrix), per 0.5 square	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	centimeters	Policy (CPCP).		
9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9734	Focused ultrasound ablation/therapeutic intervention, other than	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2014	12/31/2999
	uterine leiomyomata, with magnetic resonance (MR) guidance	Submit for Recommended Clinical Review to avoid post-service review.		
9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2015	12/31/2999
	3 implants	Submit for Recommended Clinical Review to avoid post-service review.		
9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	12/1/2015	12/31/2999
	more implants	Submit for Recommended Clinical Review to avoid post-service review.		
9757	Laminotomy (hemilaminectomy), with decompression of nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	root(s), including partial facetectomy, foraminotomy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	excision of herniated intervertebral disc, and repair of annular	Policy (CPCP).		
	defect with implantation of bone anchored annular closure			
	device, including annular defect measurement, alignment and			
	sizing assessment, and image guidance; 1 interspace, lumbar			
9757	Laminotomy (hemilaminectomy), with decompression of nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	root(s), including partial facetectomy, foraminotomy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	excision of herniated intervertebral disc, and repair of annular	Policy (CPCP).		
	defect with implantation of bone anchored annular closure			
	device, including annular defect measurement, alignment and			
	sizing assessment, and image guidance; 1 interspace, lumbar			
9764	Revascularization, endovascular, open or percutaneous, any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2021	12/31/2999
	vessel(s); with intravascular lithotripsy, includes angioplasty	Submit for Recommended Clinical Review to avoid post-service review.		
	within the same vessel(s), when performed			
9765	Revascularization, endovascular, open or percutaneous, any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2021	12/31/2999
	vessel(s); with intravascular lithotripsy, and transluminal stent	Submit for Recommended Clinical Review to avoid post-service review.		
	placement(s), includes angioplastys within the same vessel(s),			
	when performed			
9766	Revascularization, endovascular, open or percutaneous, any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2021	12/31/2999
	vessel(s); with intravascular lithotripsy and atherectomy,	Submit for Recommended Clinical Review to avoid post-service review.		
	includes angioplasty within the same vessel(s), when performed	· '		

C9767	Revascularization, endovascular, open or percutaneous, any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2021	12/31/2999
	vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the	Submit for Recommended Clinical Review to avoid post-service review.		
C9768	same vessel(s), when performed Endoscopic ultrasound-guided direct measurement of hepatic	Fill Describer to the continue	2/4/2024	12/31/2999
29768	portosystemic pressure gradient by any method (list separately	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	3/1/2021	12/31/2999
	in addition to code for primary procedure)	Policy (CPCP).		
C9768	Endoscopic ultrasound-guided direct measurement of hepatic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
59100	portosystemic pressure gradient by any method (list separately	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 1/2021	12/31/2999
	in addition to code for primary procedure)	Policy (CPCP).		
C9769	Cystourethroscopy, with insertion of temporary prostatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2020	12/31/2999
33703	implant/stent with fixation/anchor and incisional struts	Submit for Recommended Clinical Review to avoid post-service review.	10/10/2020	12/01/2000
C9772	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
20112	tibial/peroneal artery(ies), with intravascular lithotripsy, includes	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2021	12/01/2000
	angioplasty within the same vessel (s), when performed	Policy (CPCP).		
C9772	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
501.12	tibial/peroneal artery(ies), with intravascular lithotripsy, includes	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2021	12/01/2000
	angioplasty within the same vessel (s), when performed	Policy (CPCP).		
C9773	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy, and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	transluminal stent placement(s), includes angioplasty within the			
	same vessel(s), when performed	. s., (c. c.).		
C9773	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy, and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	transluminal stent placement(s), includes angioplasty within the			
	same vessel(s), when performed			
C9774	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	atherectomy, includes angioplasty within the same vessel (s),	Policy (CPCP).		
	when performed			
C9774	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	atherectomy, includes angioplasty within the same vessel (s),	Policy (CPCP).		
	when performed			
9775	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	transluminal stent placement(s), and atherectomy, includes	Policy (CPCP).		
	angioplasty within the same vessel (s), when performed			
C9775	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	transluminal stent placement(s), and atherectomy, includes	Policy (CPCP).		
	angioplasty within the same vessel (s), when performed		0/4=/005	10/01/2222
9777	Esophageal mucosal integrity testing by electrical impedance,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	transoral, includes esophagoscopy or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	esophagogastroduodenoscopy	Policy (CPCP).	0/45/005	10/01/2222
C9777	Esophageal mucosal integrity testing by electrical impedance,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/15/2021	12/31/2999
	transoral, includes esophagoscopy or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	esophagogastroduodenoscopy	Policy (CPCP).		

C9782	Blinded procedure for new york heart association (nyha) class ii	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2024	12/31/2999
	or iii heart failure, or canadian cardiovascular society (ccs) class	Submit for Recommended Clinical Review to avoid post-service review.		
	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)			
C9784	studv Gastric restrictive procedure, endoscopic sleeve gastroplasty,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
30704	with esophagogastroduodenoscopy and intraluminal tube	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	insertion, if performed, including all system and tissue anchoring			
	components	i only (or or).		
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
	with esophagogastroduodenoscopy and intraluminal tube	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	insertion, if performed, including all system and tissue anchoring			
	components			
C9785	Endoscopic outlet reduction, gastric pouch application, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
	endoscopy and intraluminal tube insertion, if performed,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including all system and tissue anchoring components	Policy (CPCP).		
C9785	Endoscopic outlet reduction, gastric pouch application, with	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
	endoscopy and intraluminal tube insertion, if performed,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	including all system and tissue anchoring components	Policy (CPCP).	0///0000	10/01/0000
C9786	Echocardiography image post processing for computer aided	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2023	12/31/2999
	detection of heart failure with preserved ejection fraction,	Submit for Recommended Clinical Review to avoid post-service review.		
C9793	including interpretation and report 3d predictive model generation for pre-planning of a cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2024	12/31/2999
C9793	procedure, using data from cardiac computed tomographic	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2024	12/31/2999
	angiography with report	Submit for Neconfinenced Chilical Neview to avoid post-service review.		
C9796	Repair of enterocutaneous fistula small intestine or colon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	(excluding anorectal fistula) with plug (e.g., porcine small	review. Check EIU policy, which is one of our Clinical Payment and Coding	., ,,	1
	intestine submucosa [sis])	Policy (CPCP).		
C9796	Repair of enterocutaneous fistula small intestine or colon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	(excluding anorectal fistula) with plug (e.g., porcine small	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	intestine submucosa [sis])	Policy (CPCP).		
C9796	Repair of enterocutaneous fistula small intestine or colon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	6/30/2024
	(excluding anorectal fistula) with plug (e.g., porcine small	Submit for Recommended Clinical Review to avoid post-service review.		
	intestine submucosa [sis])			
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
27040		service review.	4/4/4050	10/04/2000
D7210	extraction, erupted tooth requiring removal of bone and/or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	sectioning of tooth, and including elevation of mucoperiosteal	service review.		
D7220	flap if indicated removal of impacted tooth - soft tissue	Non Covered: Dragodure/coming not occurred by the Diam. Not asking the	1/1/1050	12/31/2999
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
D7230	removal of impacted tooth - partially bony	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
J1230	removal of impacted tooth - partially borry	Inon Covered. Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999

D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E0162	Sitz bath chair	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.		12/31/2999
E0210	Electric heat pad, standard	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		12/31/2999
E0215	Electric heat pad, moist	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		12/31/2999
E0217	Water circulating heat pad with pump	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		12/31/2999
E0218	Fluid circulating cold pad with pump, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.		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 preservice 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 preservice 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 preservice 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 preservice review.		12/31/2999
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice review.	1/1/2021	12/31/2999
E0274	Over-bed table	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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		EIU: Procedure/service not 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		EIU: Procedure/service not 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

E0492	Power source and control electronics unit for oral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2024	12/31/2999
	device/appliance for neuromuscular electrical stimulation of the	Submit for Recommended Clinical Review to avoid post-service review.		
	tongue muscle, controlled by phone application			
0493	Oral device/appliance for neuromuscular electrical stimulation of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2024	12/31/2999
	the tongue muscle, used in conjunction with the power source	Submit for Recommended Clinical Review to avoid post-service review.		
	and control electronics unit, controlled by phone application, 90-			
	day supply			
0530	Electronic positional obstructive sleep apnea treatment, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2024	12/31/2999
	sensor, includes all components and accessories, any type	Submit for Recommended Clinical Review to avoid post-service review.		
0616	Implantable cardiac event recorder with memory, activator and	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	programmer	Submit for Recommended Clinical Review to avoid post-service review.		
0617	External defibrillator with integrated electrocardiogram analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/16/2019	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0620	Skin piercing device for collection of capillary blood, laser, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
0650	Pneumatic compressor, non-segmental home model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0651	Pneumatic compressor, segmental home model without	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	calibrated gradient pressure	Submit for Recommended Clinical Review to avoid post-service review.		
0652	Pneumatic compressor, segmental home model with calibrated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	gradient pressure	Submit for Recommended Clinical Review to avoid post-service review.		
655	Non-segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, half arm	Submit for Recommended Clinical Review to avoid post-service review.		
0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
	PNEUMATIC COMPRESSOR, TRUNK	Submit for Recommended Clinical Review to avoid post-service review.		
0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
	PNEUMATIC COMPRESSOR, CHEST	Submit for Recommended Clinical Review to avoid post-service review.		
0660	Non-segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, full leg	Submit for Recommended Clinical Review to avoid post-service review.		
0665	Non-segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, full arm	Submit for Recommended Clinical Review to avoid post-service review.		
0666	Non-segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, half leg	Submit for Recommended Clinical Review to avoid post-service review.		
0667	Segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, full leg	Submit for Recommended Clinical Review to avoid post-service review.		
0668	Segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, full arm	Submit for Recommended Clinical Review to avoid post-service review.		
0669	Segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	compressor, half leg	Submit for Recommended Clinical Review to avoid post-service review.		
0670	Segmental pneumatic appliance for use with pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	compressor, integrated, 2 full legs and trunk	Submit for Recommended Clinical Review to avoid post-service review.		
0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0672	Segmental gradient pressure pneumatic appliance, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
	, pro	Submit for Recommended Clinical Review to avoid post-service review.		
0673	Segmental gradient pressure pneumatic appliance, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
-	5 g p p spp	Submit for Recommended Clinical Review to avoid post-service review.	====	
0675	Pneumatic compression device, high pressure, rapid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	inflation/deflation cycle, for arterial insufficiency (unilateral or	review. Check EIU policy, which is one of our Clinical Payment and Coding	/ 1/2020	12/01/2000
	initiation, activition by old, for alterial industriology (utiliately)	provider. Chook Lie policy, willor to one of our chillion raymont and obding		

E0675	Pneumatic compression device, high pressure, rapid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	inflation/deflation cycle, for arterial insufficiency (unilateral or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	bilateral system)	Policy (CPCP).		
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2007	12/31/2999
	ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	Submit for Recommended Clinical Review to avoid post-service review.		
E0677	Non-pneumatic sequential compression garment, trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E0678	Non-pneumatic sequential compression garment, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E0679	Non-pneumatic sequential compression garment, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E0680	Non-pneumatic compression controller with sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	calibrated gradient pressure	Submit for Recommended Clinical Review to avoid post-service review.		
E0681	Non-pneumatic compression controller without calibrated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	gradient pressure	Submit for Recommended Clinical Review to avoid post-service review.	_,	1-7517-255
E0682	Non-pneumatic sequential compression garment, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	9,	Submit for Recommended Clinical Review to avoid post-service review.	_,	1-7517-255
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2006	12/31/2999
	BULBS/LAMPS, TIMER AND EYE PROTECTION;	Submit for Recommended Clinical Review to avoid post-service review.		1-7517-255
	TREATMENT AREA 2 SQUARE FEET OR LESS	Cushing for Proporting Common to area post service review.		
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2006	12/31/2999
	timer and eye protection, 4 foot panel	Submit for Recommended Clinical Review to avoid post-service review.		1-7517-255
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps,		9/1/2006	12/31/2999
	timer and eye protection, 6 foot panel	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/01/2000
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2006	12/31/2999
L000-i	includes bulbs/lamps, timer and eye protection	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
E0700	SAFETY FOLIPMENT DEVICE OR ACCESSORY ANY TYPE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
_0700	OAI ETT EQUITMENT, BEVIOE OR AGGEGGORT, ANT THE	service review.	1/1/1330	12/01/2000
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
_0702	Oranial electrotricrapy sumulation (ees) system, any type	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/13/2024	12/01/2000
		Policy (CPCP).		
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
L0702	Oranial electrotricrapy sumulation (ees) system, any type	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/13/2024	12/01/2000
		Policy (CPCP).		
E0732	Cranial electrotherapy stimulation (ces) system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
L07 02	Oranial electrotricrapy stimulation (ees) system, any type	Submit for Recommended Clinical Review to avoid post-service review.	2/10/2024	3/14/2024
E0733	Transcutaneous electrical nerve stimulator for electrical		2/15/2024	12/31/2999
_0700	stimulation of the trigeminal nerve	Submit for Recommended Clinical Review to avoid post-service review.	2/10/2024	12/01/2000
E0734	External upper limb tremor stimulator of the peripheral nerves of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
_07.04	the wrist	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/13/2024	12/01/2000
	tile wilst	Policy (CPCP).		
E0734	External upper limb tremor stimulator of the peripheral perves of	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
_07.04	the wrist	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/13/2024	12/01/2000
	tile wilst	Policy (CPCP).		
E0734	External upper limb tremor stimulator of the peripheral nerves of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	5/14/2024
_0104	the wrist	Submit for Recommended Clinical Review to avoid post-service review.	2, 13,2024	3/ 14/2024
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
LU133	Indir-ilivasive vagus fierve stilliulator	,	2/ 13/2024	12/31/2999
E0736	Transcutaneous tibial nerve stimulator	Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
EU130	Transcutaneous libiai nerve stimulator	,	3/1/2024	12/31/2999
	I	Submit for Recommended Clinical Review to avoid post-service review.	l	

E0740	Non-implanted pelvic floor electrical stimulator, complete	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	system	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0740	Non-implanted pelvic floor electrical stimulator, complete	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	system	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0747	Osteogenesis stimulator, electrical, non-invasive, other than	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	spinal applications	Submit for Recommended Clinical Review to avoid post-service review.		
0755	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
0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0761	Non-thermal pulsed high frequency radiowaves, high peak	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	power electromagnetic energy treatment device	Submit for Recommended Clinical Review to avoid post-service review.		
0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0764	FUNCTIONAL NEUROMUSCULAR STIMULATION.	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
	TRANSCUTANEOUS STIMULATION OF SEQUENTIAL	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	MUSCLE GROUPS OF AMBULATION WITH COMPUTER	Policy (CPCP).		
	CONTROL, USED FOR WALKING BY SPINAL CORD			
	INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF			
	TRAINING PROGRAM			
0764	FUNCTIONAL NEUROMUSCULAR STIMULATION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
	TRANSCUTANEOUS STIMULATION OF SEQUENTIAL	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	MUSCLE GROUPS OF AMBULATION WITH COMPUTER	Policy (CPCP).		
	CONTROL, USED FOR WALKING BY SPINAL CORD			
	INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF			
	TRAINING PROGRAM			
0766	Electrical stimulation device used for cancer treatment, includes		6/15/2017	12/31/2999
	all accessories, any type	Submit for Recommended Clinical Review to avoid post-service review.		
0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	WOUND TREATMENT DEVICE, NOT OTHERWISE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CLASSIFIED	Policy (CPCP).	10/15/00/14	10/01/0000
769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	WOUND TREATMENT DEVICE, NOT OTHERWISE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
-0704	CLASSIFIED	Policy (CPCP).	44/4/0005	40/04/0000
0781	Ambulatory infusion pump, single or multiple channels, electric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2005	12/31/2999
	or battery operated, with administrative equipment, worn by	Submit for Recommended Clinical Review to avoid post-service review.		
2020	patient	FILL Decoding (comics not using homes)	40/45/0044	40/04/0000
0830	Ambulatory traction device, all types, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

E0830	Ambulatory traction device, all types, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	, ,,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		1-1-1-1-1-1
		Policy (CPCP).		
0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	TO OTHER THAN MANDIBLE	Policy (CPCP).		
0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	TO OTHER THAN MANDIBLE	Policy (CPCP).		
E0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0855	Cervical traction equipment not requiring additional stand or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	frame	review. Check EIU policy, which is one of our Clinical Payment and Coding		
-0055		Policy (CPCP).	40/45/0044	10/04/0000
0855	Cervical traction equipment not requiring additional stand or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/15/2014	12/31/2999
	frame	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
E0856	Cervical traction device, with inflatable air bladder(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
_0000	Corvida traditori dovido, with initiatable all bladdor(d)	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2020	12/01/2000
		Policy (CPCP).		
0856	Cervical traction device, with inflatable air bladder(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
	osi iliaa aaaaan aanaa, iliaa aaaaa aa aaaaa (o)	review. Check EIU policy, which is one of our Clinical Payment and Coding	07.172020	.2,01,200
		Policy (CPCP).		
E0860	Traction equipment, overdoor, cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0860	Traction equipment, overdoor, cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0890	Traction frame, attached to footboard, pelvic traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0890	Traction frame, attached to footboard, pelvic traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0920	Fracture frame, attached to bed, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	<u> </u>	
0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

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

E0992	Manual wheelchair accessory, solid seat insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
1000)	Submit for Recommended Clinical Review to avoid post-service review.	0/4/0000	10/04/0000
002	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
1003	Wheelchair accessory, power seating system, recline only,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
1003	without shear reduction	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
004	Wheelchair accessory, power seating system, recline only, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
1004	mechanical shear reduction	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
1005	Wheelchair accessory, power seating system, recline only, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
000	power shear reduction	Submit for Recommended Clinical Review to avoid post-service review.	3/24/2012	12/01/2000
006	Wheelchair accessory, power seating system, combination tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	and recline, without shear reduction	Submit for Recommended Clinical Review to avoid post-service review.		
1007	Wheelchair accessory, power seating system, combination tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	and recline, with mechanical shear reduction	Submit for Recommended Clinical Review to avoid post-service review.		
1008	Wheelchair accessory, power seating system, combination tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	and recline, with power shear reduction	Submit for Recommended Clinical Review to avoid post-service review.		
1009	Wheelchair accessory, addition to power seating system,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	mechanically linked leg elevation system, including pushrod and leg rest, each	Submit for Recommended Clinical Review to avoid post-service review.		
1010	Wheelchair accessory, addition to power seating system, power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	leg elevation system, including leg rest, pair	Submit for Recommended Clinical Review to avoid post-service review.		
1012	Wheelchair accessory, addition to power seating system, center	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	12/31/2999
	mount power elevating leg rest/platform, complete system, any	Submit for Recommended Clinical Review to avoid post-service review.		
	type, each			
1028	Wheelchair accessory, manual swingaway, retractable or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	removable mounting hardware for joystick, other control	Submit for Recommended Clinical Review to avoid post-service review.		
	interface or positioning accessory			
1083	Hemi-wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	elevating leg rest	Submit for Recommended Clinical Review to avoid post-service review.		
1085	Hemi-wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
100=	foot rests	Submit for Recommended Clinical Review to avoid post-service review.	0/45/0044	10/01/0000
1087	High strength lightweight wheelchair, fixed full length arms,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
4470	swing away detachable elevating leg rests	Submit for Recommended Clinical Review to avoid post-service review.	0/45/0044	40/04/0000
1170	Amputee wheelchair, fixed full length arms, swing away	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
1171	detachable elevating legrests Amputee wheelchair, fixed full length arms, without footrests or		3/15/2014	12/31/2999
11/1	legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/ 13/2014	12/31/2999
1172	Amputee wheelchair, detachable arms (desk or full length)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
· · · · · ·	without footrests or legrest	Submit for Recommended Clinical Review to avoid post-service review.	5, .5, 20 1 1	12,01,2000
1180	Amputee wheelchair, detachable arms (desk or full length)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	swing away detachable footrests	Submit for Recommended Clinical Review to avoid post-service review.		
1195	Heavy duty wheelchair, fixed full length arms, swing away	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	detachable elevating legrests	Submit for Recommended Clinical Review to avoid post-service review.		
1200	Amputee wheelchair, fixed full length arms, swing away	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	detachable footrest	Submit for Recommended Clinical Review to avoid post-service review.		
1220	Wheelchair; specially sized or constructed, (indicate brand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	name, model number, if any) and justification	Submit for Recommended Clinical Review to avoid post-service review.		
1221	Wheelchair with fixed arm, footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

E1225	Wheelchair accessory, manual semi-reclining back, (recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	greater than 15 degrees, but less than 80 degrees), each	Submit for Recommended Clinical Review to avoid post-service review.		
1226	Wheelchair accessory, manual fully reclining back, (recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	greater than 80 degrees), each	Submit for Recommended Clinical Review to avoid post-service review.		
1227	Special height arms for wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1228	Special back height for wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	SPECIFIED	Submit for Recommended Clinical Review to avoid post-service review.		
1230	Power operated vehicle (three or four wheel nonhighway)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	specify brand name and model number	Submit for Recommended Clinical Review to avoid post-service review.		
1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	seating system	Submit for Recommended Clinical Review to avoid post-service review.		
1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	SPECIFIED	Submit for Recommended Clinical Review to avoid post-service review.		
1285	Heavy duty wheelchair, fixed full length arms, swing away	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	detachable footrest	Submit for Recommended Clinical Review to avoid post-service review.		
1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1300	Whirlpool, portable (overtub type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
1301	Whirlpool tub, walk-in, portable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1310	Whirlpool, non-portable (built-in type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
1355	Stand/rack	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
E1629	Tablo hemodialysis system for the billable dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	· ·	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	· ·	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E1700	Jaw motion rehabilitation system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
E1701	Replacement cushions for jaw motion rehabilitation system, pkg.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	Of 6	service review.		
1702	Replacement measuring scales for jaw motion rehabilitation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	system, pkg. Of 200	service review.		
2120	Pulse generator system for tympanic treatment of inner ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
	endolymphatic fluid	Submit for Recommended Clinical Review to avoid post-service review.		
2201	Manual wheelchair accessory, nonstandard seat frame, width	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	greater than or equal to 20 inches and less than 24 inches	Submit for Recommended Clinical Review to avoid post-service review.		
E2202		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	27 inches	Submit for Recommended Clinical Review to avoid post-service review.		
E2203	Manual wheelchair accessory, nonstandard seat frame depth,		6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

E2204	Manual wheelchair accessory, nonstandard seat frame depth,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	22 to 25 inches	Submit for Recommended Clinical Review to avoid post-service review.		
E2206	Manual wheelchair accessory, wheel lock assembly, complete,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	6/1/2006	12/31/2999
	EACH	service review.		
E2209	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	PROPULSION TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.		
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.		
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	ANY SIZE, EACH			
E2214	MANUAL WHEEL CHAIR ACCESSORY PNEUMATIC CASTER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/01/2000
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
LZZ 10	PNEUMATIC CASTER TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/01/2000
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
_2210	PROPULSION TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
=2217	·	·	0/1/2000	12/31/2999
-0040	CASTER TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
=0010	TIRE, ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/4/0000	10/01/0000
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE,		6/1/2006	12/31/2999
	ANY SIZE, EACH	Submit for Recommended Clinical Review to avoid post-service review.		
=2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	tire, any size, replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	(removable), any size, replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	with integrated wheel, any size, replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.		
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	SYSTEM AND LOCK, COMPLETE, EACH	Submit for Recommended Clinical Review to avoid post-service review.		
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
	SYSTEM	Submit for Recommended Clinical Review to avoid post-service review.		
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
	SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY			1 - 1 - 1 - 1 - 1
	TYPE MOUNTING HARDWARE			
E2291	Back, planar, for pediatric size wheelchair including fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	attaching hardware	Submit for Recommended Clinical Review to avoid post-service review.	., 1,2000	12/01/2000
E2292	Seat, planar, for pediatric size wheelchair including fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
L	attaching hardware	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2003	12/31/2333
E2202			1/1/2005	12/21/2000
E2293	Back, contoured, for pediatric size wheelchair including fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
E0004	attaching hardware	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0005	40/04/0000
E2294	Seat, contoured, for pediatric size wheelchair including fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	attaching hardware	Submit for Recommended Clinical Review to avoid post-service review.		l

E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
	WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	Submit for Recommended Clinical Review to avoid post-service review.		
2298	Complex rehabilitative power wheelchair accessory, power seat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	elevation system, any type	Submit for Recommended Clinical Review to avoid post-service review.	17 172021	12/01/2000
2300	Wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	3/31/2024
	, , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
2301	Wheelchair accessory, power standing system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	12/31/2999
	371 3 37	Submit for Recommended Clinical Review to avoid post-service review.		
2310	Power wheelchair accessory, electronic connection between	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2007	12/31/2999
	wheelchair controller and one power seating system motor,	Submit for Recommended Clinical Review to avoid post-service review.		
	including all related electronics, indicator feature, mechanical	, i		
	function selection switch, and fixed mounting hardware			
2311	Power wheelchair accessory, electronic connection between	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2007	12/31/2999
	wheelchair controller and two or more power seating system	Submit for Recommended Clinical Review to avoid post-service review.		
	motors, including all related electronics, indicator feature,	, i		
	mechanical function selection switch, and fixed mounting			
	hardware			
2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	CONTROL INTERFACE, MINI-PROPORTIONAL	Submit for Recommended Clinical Review to avoid post-service review.		
2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	UPGRADE TO EXPANDABLE CONTROLLER,	Submit for Recommended Clinical Review to avoid post-service review.		
2321	Power wheelchair accessory, hand control interface, remote	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	joystick, nonproportional, including all related electronics,	Submit for Recommended Clinical Review to avoid post-service review.		
	mechanical stop switch, and fixed mounting hardware			
2322	Power wheelchair accessory, hand control interface, multiple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	mechanical switches, nonproportional, including all related	Submit for Recommended Clinical Review to avoid post-service review.		
	electronics, mechanical stop switch, and fixed mounting			
	hardware			
2323	Power wheelchair accessory, specialty joystick handle for hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	control interface, prefabricated	Submit for Recommended Clinical Review to avoid post-service review.		
2324	Power wheelchair accessory, chin cup for chin control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2325	Power wheelchair accessory, sip and puff interface,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	nonproportional, including all related electronics, mechanical	Submit for Recommended Clinical Review to avoid post-service review.		
	stop switch, and manual swingaway mounting hardware			
2326	Power wheelchair accessory, breath tube kit for sip and puff	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	interface	Submit for Recommended Clinical Review to avoid post-service review.		
2327	Power wheelchair accessory, head control interface,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	mechanical, proportional, including all related electronics,	Submit for Recommended Clinical Review to avoid post-service review.		
	mechanical direction change switch, and fixed mounting			
	hardware			
2328	Power wheelchair accessory, head control or extremity control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	interface, electronic, proportional, including all related	Submit for Recommended Clinical Review to avoid post-service review.		
2000	electronics and fixed mounting hardware	INDON DE LA CASTA DEL CASTA DE LA CASTA DEL CASTA DE LA CASTA DE L	01410000	10/04/2000
2329	Power wheelchair accessory, head control interface, contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	switch mechanism, nonproportional, including all related	Submit for Recommended Clinical Review to avoid post-service review.		
	electronics, mechanical stop switch, mechanical direction			
	change switch, head array, and fixed mounting hardware			

E2330	Power wheelchair accessory, head control interface, proximity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	switch mechanism, nonproportional, including all related	Submit for Recommended Clinical Review to avoid post-service review.		
	electronics, mechanical stop switch, mechanical direction			
	change switch, head array, and fixed mounting hardware			
2331	Power wheelchair accessory, attendant control, proportional,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	including all related electronics and fixed mounting hardware	Submit for Recommended Clinical Review to avoid post-service review.		
2340		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	23 inches	Submit for Recommended Clinical Review to avoid post-service review.		
2341	Power wheelchair accessory, nonstandard seat frame width, 24-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	27 inches	Submit for Recommended Clinical Review to avoid post-service review.		
2342	Power wheelchair accessory, nonstandard seat frame depth, 20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	or 21 inches	Submit for Recommended Clinical Review to avoid post-service review.		
2343	Power wheelchair accessory, nonstandard seat frame depth, 22-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	25 inches	Submit for Recommended Clinical Review to avoid post-service review.		
2351	Power wheelchair accessory, electronic interface to operate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	speech generating device using power wheelchair control	Submit for Recommended Clinical Review to avoid post-service review.		
	interface	· ·		
2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2012	12/31/2999
	SEALED LEAD ACID BATTERY, EACH	Submit for Recommended Clinical Review to avoid post-service review.		
2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2012	12/31/2999
	LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED	Submit for Recommended Clinical Review to avoid post-service review.		
	GLASSMAT)			
2360	Power wheelchair accessory, 22 nf non-sealed lead acid battery,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	each	Submit for Recommended Clinical Review to avoid post-service review.		
2361	Power wheelchair accessory, 22nf sealed lead acid battery,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	each, (e. G. Gel cell, absorbed glassmat)	Submit for Recommended Clinical Review to avoid post-service review.		
2362	Power wheelchair accessory, group 24 non-sealed lead acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	battery, each	Submit for Recommended Clinical Review to avoid post-service review.		
2363	Power wheelchair accessory, group 24 sealed lead acid battery,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	each (e. G. Gel cell, absorbed glassmat)	Submit for Recommended Clinical Review to avoid post-service review.		1,-,,
2364	Power wheelchair accessory, u-1 non-sealed lead acid battery,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	each	Submit for Recommended Clinical Review to avoid post-service review.	07.72000	12/01/2000
2365	Power wheelchair accessory, u-1 sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
2000	(e. G. Gel cell, absorbed glassmat)	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
2366	Power wheelchair accessory, battery charger, single mode, for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
2000	use with only one battery type, sealed or non-sealed, each	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
2367	Power wheelchair accessory, battery charger, dual mode, for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
2001	use with either battery type, sealed or non-sealed, each	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
2071	LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
	GLASSMAT), EACH	Journal for Necommended Chillical Neview to avoid post-service review.		
2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
2012	SEALED LEAD ACID BATTERY, EACH	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/3/1/2888
2373	Power wheelchair accessory, hand or chin control interface,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
.2313	•		3/15/2014	12/31/2999
	compact remote joystick, proportional, including fixed mounting	Submit for Recommended Clinical Review to avoid post-service review.		
	hardware			

E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK	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
	(NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY			
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
E23/5	CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	messages, less than or equal to 8 minutes recording time	Submit for Recommended Clinical Review to avoid post-service review.	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	12/01/2000
E2502	Speech generating device, digitized speech, using pre-recorded		1/1/1950	12/31/2999
	messages, greater than 8 minutes but less than or equal to 20 minutes recording time	Submit for Recommended Clinical Review to avoid post-service review.		
E2504	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	messages, greater than 20 minutes but less than or equal to 40 minutes recording time	Submit for Recommended Clinical Review to avoid post-service review.		
E2506	Speech generating device, digitized speech, using pre-recorded	,	1/1/1950	12/31/2999
	messages, greater than 40 minutes recording time	Submit for Recommended Clinical Review to avoid post-service review.		
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		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		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

E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	INCHES OR GREATER, ANY DEPTH	Submit for Recommended Clinical Review to avoid post-service review.		
2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Submit for Recommended Clinical Review to avoid post-service review.		
2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Submit for Recommended Clinical Review to avoid post-service review.		
2609		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	SIZE	Submit for Recommended Clinical Review to avoid post-service review.		1
2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY	Submit for Recommended Clinical Review to avoid post-service review.	., .,	12/01/2000
	TYPE MOUNTING HARDWARE	Capital for resolutionada camada review to avoia post corvido foriow.		
2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
-012	INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY	Submit for Recommended Clinical Review to avoid post-service review.	17 172000	12/01/2000
	TYPE MOUNTING HARDWARE	Journal for Necommended Chillical Neview to avoid post-service review.		
2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
2013	WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
	ANY TYPE MOUNTING HARDWARE	Submit for Necommended Chilical Neview to avoid post-service review.		
2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
10 14		Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2045	ANY TYPE MOUNTING HARDWARE	MD Odtada Davida da d	4/4/0005	40/04/0000
2615		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT,	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING ANY TYPE MOUNTING HARDWARE		4/4/0005	40/04/0000
2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT,	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING ANY TYPE MOUNTING HARDWARE			
2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY	, , , , , , , , , , , , , , , , , , ,	1/1/2005	12/31/2999
	SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	Submit for Recommended Clinical Review to avoid post-service review.		
2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22	Submit for Recommended Clinical Review to avoid post-service review.		
	INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING			
	HARDWARE			
2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2005	12/31/2999
	BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR	Submit for Recommended Clinical Review to avoid post-service review.		
	GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING			
	HARDWARE			
2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
	ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	•		
2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
	ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY	Submit for Recommended Clinical Review to avoid post-service review.		
	DEPTH			
2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
.02 .	CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES,	Submit for Recommended Clinical Review to avoid post-service review.	17.172011	12/01/2000
	ANY DEPTH	Cubility for recognification of the state of		
2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
2020	CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER,	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2011	12/31/2333
		Cubinit for Neconfinenced Chilical Neview to avoid post-service feview.		
2626	ANY DEPTH WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE	MD Criteria: Precedure/convice reviewed against Medical Policy Criteria	3/15/2014	12/31/2999
2626		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED,	Submit for Recommended Clinical Review to avoid post-service review.		
	ADJUSTABLE			

E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED,	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
	ADJUSTABLE RANCHO TYPE		0/45/0044	40/04/0000
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2014	12/31/2999
	ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	Submit for Recommended Clinical Review to avoid post-service review.	0/10/2011	12/6/1/2000
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		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)		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 preservice 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

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,	EIU: Procedure/service not reimbursed 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
	as part of a therapy plan of care			
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 preservice 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 preservice 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		EIU: Procedure/service not reimbursed 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

G0455	Preparation with instillation of fecal microbiota by any method,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	including assessment of donor specimen	Submit for Recommended Clinical Review to avoid post-service review.		
G0460	Autologous platelet rich plasma or other blood-derived product	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	for non-diabetic chronic wounds/ulcers, including as applicable	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	phlebotomy, centrifugation or mixing, and all other preparatory	Policy (CPCP).		
	procedures, administration and dressings, per treatment	, (,-		
G0460	Autologous platelet rich plasma or other blood-derived product	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	for non-diabetic chronic wounds/ulcers, including as applicable	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	phlebotomy, centrifugation or mixing, and all other preparatory	Policy (CPCP).		
	procedures, administration and dressings, per treatment	, (,		
G0465	Autologous platelet rich plasma (PRP) or other blood-derived	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
	product for diabetic chronic wounds/ulcers, using an FDA-	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	cleared device for this indication, (includes as applicable	Policy (CPCP).		
	administration, dressings, phlebotomy, centrifugation or mixing,			
	and all other preparatory procedures, per treatment)			
G0465	Autologous platelet rich plasma (PRP) or other blood-derived	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2022	12/31/2999
	product for diabetic chronic wounds/ulcers, using an FDA-	review. Check EIU policy, which is one of our Clinical Payment and Coding		1-1-1-1-1-1
	cleared device for this indication, (includes as applicable	Policy (CPCP).		
	administration, dressings, phlebotomy, centrifugation or mixing,			
	and all other preparatory procedures, per treatment)			
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	9/14/2024
30010	(services for subdermal rod implant)	Submit for Recommended Clinical Review to avoid post-service review.	17 172010	0/11/2021
G0518	Removal with reinsertion, non-biodegradable drug delivery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	9/14/2024
00010	implants, 4 or more (services for subdermal implants)	Submit for Recommended Clinical Review to avoid post-service review.	17 172010	0/11/2021
G2082	Office or other outpatient visit for the evaluation and		8/1/2021	12/31/2999
02002	management of an established patient that requires the	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2021	12/01/2000
	supervision of a physician or other qualified health care	oubline for recommended official review to avoid post-service review.		
	professional and provision of up to 56 mg of esketamine nasal			
	self-administration, includes 2 hours post-administration			
	observation			
G2083	Office or other outpatient visit for the evaluation and	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2021	12/31/2999
32003	management of an established patient that requires the	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2021	12/31/2999
	supervision of a physician or other qualified health care	Journal for Neconfinenced Clinical Neview to avoid post-service review.		
	professional and provision of greater than 56 mg esketamine			
	, , , , , , , , , , , , , , , , , , , ,			
	nasal self-administration, includes 2 hours post-administration			
G8395	observation LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
30393	OR DOCUMENTATION AS NORMAL OR	service review.	1/1/2000	12/31/2999
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
00090	PERFORMED OR DOCUMENTED	service review.	1/1/2000	12/31/2999
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED,		1/1/2008	12/31/2999
00001	INCLUDING DOCUMENTATION OF THE	service review.	17 172000	12/01/2000
G8399	Patient with documented results of a central dual-energy x-ray		1/1/2008	12/31/2999
20000	absorptiometry (dxa) ever being performed	service review.	17 172000	12/01/2000
G8400	Patient with central dual-energy x-ray absorptiometry (dxa)		1/1/2008	12/31/2999
23100	results not documented, reason not given	service review.	1, 1,2000	12/01/2000
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
00404	AND DOCUMENTED	service review.	1/1/2000	12/3/1/2333
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
30403		Inon covered. Procedure/service not covered by the Plan. Not subject to pre- service review.	17 172000	12/3/1/2333
	PERFORMED	SELVICE TEVIEW.		

G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.		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 preservice review.		12/31/2999
G8421	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.		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 preservice 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 preservice review.	1/1/2008	12/31/2999
G8431		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice review.	1/1/2008	12/31/2999
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999
G8451	Beta-blocker therapy for Ivef <=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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2008	12/31/2999

G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
	receptor blocker (arb) therapy not prescribed, reason not given	service review.		
8476	Most recent blood pressure has a systolic measurement of <	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
8477	140 mmhg and a diastolic measurement of < 90 mmhg Most recent blood pressure has a systolic measurement of	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
04//	>=140 mmhq and/or a diastolic measurement of >=90 mmhq	service review.	1/1/2006	12/31/2999
8478	Blood pressure measurement not performed or documented,		1/1/2008	12/31/2999
10470	reason not given	service review.	1/ 1/2006	12/31/2999
88482	INFLUENZA IMMUNIZATION ADMINISTERED OR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
0402	PREVIOUSLY RECEIVED	service review.	1/1/2006	12/31/2999
8483	Influenza immunization was not administered for reasons	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
.0.00	documented by clinician (e.g., patient allergy or other medical	service review.	17 172000	12/01/2000
	reasons, patient declined or other patient reasons, vaccine not	561 VI66 16 VI6W.		
	available or other system reasons)			
8484	Influenza immunization was not administered, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
	g	service review.		12.0
88559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR)	service review.		
	FOR AN OTOLOGIC EVALUATION			
8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	THE EAR WITHIN THE PREVIOUS 90 DAYS	service review.		
8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY	service review.		
	OF ACTIVE DRAINAGE MEASURE			
S8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90	service review.		
	DAYS			
98563	Patient not referred to a physician (preferably a physician with	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	training in disorders of the ear) for an otologic evaluation,	service review.		
	reason not given			
8564	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR)	service review.		
	FOR AN OTOLOGIC EVALUATION, REASON NOT			
	SPECIFIED)			
8565	VERIFICATION AND DOCUMENTATION OF SUDDEN OR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	RAPIDLY PROGRESSIVE HEARING LOSS	service review.		
88566	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY	service review.		
	PROGRESSIVE HEARING LOSS MEASURE			
S8567	PATIENT DOES NOT HAVE VERIFICATION AND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	DOCUMENTATION OF SUDDEN OR RAPIDLY	service review.		
	PROGRESSIVE HEARING LOSS			
8568	Patient was not referred to a physician (preferably a physician	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	with training in disorders of the ear) for an otologic evaluation,	service review.		
	reason not given			
88569	Prolonged postoperative intubation (> 24 hrs) required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
		service review.		
8570	Prolonged postoperative intubation (> 24 hrs) not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
		service review.		

G8575	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED DIALYSIS	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2010	12/31/2999
G8576	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	REQUIRED	service review.		
G8577	Re-exploration required due to mediastinal bleeding with or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	without tamponade, graft occlusion, valve dysfunction or other	service review.		
	cardiac reason			
S8578	Re-exploration not required due to mediastinal bleeding with or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	without tamponade, graft occlusion, valve dysfunction or other	service review.		
	cardiac reason			
G8598	Aspirin or another antiplatelet therapy used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
		service review.		
S8599	Aspirin or another antiplatelet therapy not used, reason not	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	given	service review.		
38600	Iv thrombolytic therapy initiated within 4.5 hours (<= 270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	minutes) of time last known well	service review.		
8601	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	minutes) of time last known well for reasons documented by	service review.		
	clinician (e.g. patient enrolled in clinical trial for stroke, patient			
	admitted for elective carotid intervention)			
8602	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2010	12/31/2999
	minutes) of time last known well, reason not given	service review.		
9050	Oncology; primary focus of visit; work-up, evaluation, or staging	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	at the time of cancer diagnosis or recurrence (for use in a	service review.		
	medicare-approved demonstration project)			
9051		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	disease is staged or restaged, discussion of treatment options,	service review.		
	supervising/coordinating active cancer directed therapy or			
	managing consequences of cancer directed therapy (for use in a			
	medicare-approved demonstration project)			
9052	Oncology; primary focus of visit; surveillance for disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	recurrence for patient who has completed definitive cancer-	service review.		,
	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)			
9053	Oncology; primary focus of visit; expectant management of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
- 300	patient with evidence of cancer for whom no cancer directed	Iservice review.		.2,0.,2000
	therapy is being administered or arranged at present; cancer	os no ronow.		
	directed therapy might be considered in the future (for use in a			
	medicare-approved demonstration project)			
9054	Oncology; primary focus of visit; supervising, coordinating or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
10004	managing care of patient with terminal cancer or for whom other	service review.	1/1/2000	12/3/1/2333
	medical illness prevents further cancer treatment; includes	SCI VICO ICVICAN.		
	symptom management, end-of-life care planning, management			
	of palliative therapies (for use in a medicare-approved			
0055	demonstration project)	Non Covered, Presedure/service not severed by the Plan. Not subject to the	1/1/2006	10/21/2000
S9055	Oncology; primary focus of visit; other, unspecified service not	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	otherwise listed (for use in a medicare-approved demonstration	service review.		
	project)			

G9056	Oncology; practice guidelines; management adheres to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines (for use in a medicare-approved demonstration	service review.		
	project)			
G9057	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines as a result of patient enrollment in an institutional	service review.		
	review board approved clinical trial (for use in a medicare-			
	approved demonstration project)			
G9058	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines because the treating physician disagrees with	service review.		
	guideline recommendations (for use in a medicare-approved			
	demonstration project)			
G9059	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines because the patient, after being offered treatment	service review.		
	consistent with guidelines, has opted for alternative treatment or			
	management, including no treatment (for use in a medicare-			
	approved demonstration project)			
G9060	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines for reason(s) associated with patient comorbid illness	service review.		
	or performance status not factored into guidelines (for use in a			
	medicare-approved demonstration project)			
G9061	Oncology; practice guidelines; patient's condition not addressed	· · · · · · · · · · · · · · · · · · ·	1/1/2006	12/31/2999
	by available guidelines (for use in a medicare-approved	service review.		
	demonstration project)			
G9062	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	guidelines for other reason(s) not listed (for use in a medicare-	service review.		
	approved demonstration project)			
G9063	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	extent of disease initially established as stage i (prior to neo-	service review.		
	adjuvant therapy, if any) with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			
G9064	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	extent of disease initially established as stage ii (prior to neo-	service review.		
	adjuvant therapy, if any) with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)		4/4/0000	10/01/0000
G9065	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	extent of disease initially established as stage iii a (prior to neo-	service review.		
	adjuvant therapy, if any) with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-			
00000	approved demonstration project)	Non-Occupied Broadway/control of the Not Control of	4/4/0000	40/04/0000
G9066	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	stage iii b- iv at diagnosis, metastatic, locally recurrent, or	service review.		
	progressive (for use in a medicare-approved demonstration			
00007	project)	No. Const. Brooker (cont. or to see the the Blook No. 1)	4/4/0000	40/04/0000
G9067	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	extent of disease unknown, staging in progress, or not listed (for	service review.		
	use in a medicare-approved demonstration project)			

G9068	Oncology; disease status; limited to small cell and combined	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	small cell/non-small cell; extent of disease initially established	service review.		1.2.0.1.200
	as limited with no evidence of disease progression, recurrence,			
	or metastases (for use in a medicare-approved demonstration			
	project)			
G9069	Oncology; disease status; small cell lung cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	small cell and combined small cell/non-small cell; extensive	service review.		
	stage at diagnosis, metastatic, locally recurrent, or progressive			
	(for use in a medicare-approved demonstration project)			
G9070	Oncology; disease status; small cell lung cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	small cell and combined small cell/non-small; extent of disease	service review.		
	unknown, staging in progress, or not listed (for use in a			
G9071	medicare-approved demonstration project)	Non-Covered Describing to miss and sovered by the Dian. Not subject to man	4/4/0000	12/31/2999
G9071	Oncology; disease status; invasive female breast cancer (does	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
	not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and	iservice review.		
	er and/or pr positive; with no evidence of disease progression,			
	recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9072	Oncology; disease status; invasive female breast cancer (does	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
00012	not include ductal carcinoma in situ); adenocarcinoma as	service review.	17 172000	12/01/2000
	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)			
G9073	Oncology; disease status; invasive female breast cancer (does	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	not include ductal carcinoma in situ); adenocarcinoma as	service review.		
	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)			
G9074	Oncology; disease status; invasive female breast cancer (does	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	not include ductal carcinoma in situ); adenocarcinoma as	service review.		
	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			
C007E	demonstration project) Oncology; disease status; invasive female breast cancer (does	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	10/21/2000
G9075	not include ductal carcinoma in situ); adenocarcinoma as		1/1/2006	12/31/2999
	predominant cell type; m1 at diagnosis, metastatic, locally	service review.		
	recurrent, or progressive (for use in a medicare-approved			
	demonstration project)			
G9077	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
03011	adenocarcinoma as predominant cell type; t1-t2c and gleason 2-		1/ 1/2000	12/31/2333
	7 and psa < or equal to 20 at diagnosis with no evidence of	ISON VIOLE TO VICEW.		
	disease progression, recurrence, or metastases (for use in a			

G9078	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; t2 or t3a gleason 8-	service review.	., .,	1270172000
	10 or psa > 20 at diagnosis with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			
G9079	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; t3b-t4, any n; any t,	service review.		
	n1 at diagnosis with no evidence of disease progression,			
	recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9080	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	adenocarcinoma; after initial treatment with rising psa or failure	service review.		
	of psa decline (for use in a medicare-approved demonstration			
G9083	Oncelogy disease status prostate concer limited to	Non Covered Presedure/service not severed by the Plan. Not subject to pre-	1/1/2006	12/31/2999
39003	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
	progress, or not listed (for use in a medicare-approved	Iservice review.		
	demonstration project)			
G9084	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
00001	cancer, adenocarcinoma as predominant cell type; extent of	service review.	17 172000	12/01/2000
	disease initially established as t1-3, n0, m0 with no evidence of	osiviso forion.		
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9085	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	disease initially established as t4, n0, m0 with no evidence of			
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9086	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	disease initially established as t1-4, n1-2, m0 with no evidence			
	of disease progression, recurrence, or metastases (for use in a			
00007	medicare-approved demonstration project)	Non-Consent Described to the Consent to the Discontinuity of the Consent to the C	4/4/0000	40/04/0000
G9087	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with	service review.		
	current clinical, radiologic, or biochemical evidence of disease			
	(for use in a medicare-approved demonstration project)			
G9088	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
00000	cancer, adenocarcinoma as predominant cell type; m1 at	Iservice review.	17 172000	12/01/2000
	diagnosis, metastatic, locally recurrent, or progressive without	OCI VICO I CYTOW.		
	current clinical, radiologic, or biochemical evidence of disease			
	(for use in a medicare-approved demonstration project)			
G9089	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	disease unknown, staging in progress, or not listed (for use in a			
	medicare-approved demonstration project)			

G9090	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	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)			
G9091	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	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)			
G9092	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	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)			
G9093	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	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)		4440000	40/04/0000
G9094	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; m1 at	service review.		
	diagnosis, metastatic, locally recurrent, or progressive (for use			
00005	in a medicare-approved demonstration project)	Non-Ossessi December (1997)	4/4/0000	40/04/0000
G9095	Oncology; disease status; rectal cancer, limited to invasive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	service review.		
	disease unknown, staging in progress, or not listed (for use in a			
G9096	medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant	service review.	1/1/2006	12/31/2999
	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)			
G9097	Oncology; disease status; esophageal cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
J9091	adenocarcinoma or squamous cell carcinoma as predominant	service review.	1/1/2000	12/31/2999
	cell type; extent of disease initially established as t4, any n, m0	SCI VICE TOVICW.		
	(prior to neo-adjuvant therapy, if any) with no evidence of			
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9098	Oncology; disease status; esophageal cancer, limited to	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	adenocarcinoma or squamous cell carcinoma as predominant	Iservice review.	,2000	12,5 ., 2000
	cell type; m1 at diagnosis, metastatic, locally recurrent, or			
	progressive (for use in a medicare-approved demonstration			
	Ir 3. 555.15 (15. 555 II. 5 III. 5			

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

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 preservice 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 preservice 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)	, , ,	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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2006	12/31/2999

G9124	Oncology; disease status; chronic myelogenous leukemia,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	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	service review.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.2.5 1.2555
	demonstration project)			
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	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
00100	demonstration project)		4440000	10/01/0000
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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2007	12/31/2999

G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2007	12/31/2999
	LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR	service review.	., .,	. = , 0 . , = 000
	DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION	55.115.15.115.11		
	(FOR USE IN A MEDICARE-APPROVED DEMONSTRATION			
	PROJECT)			
9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2007	12/31/2999
	LYMPHOMA, ANY CELLULAR CLASSIFICATION;	service review.		
	RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-			
	APPROVED DEMONSTRATION PROJECT)			
9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2007	12/31/2999
	LYMPHOMA, ANY CELLULAR CLASSIFICATION;	service review.		
	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)			
9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2007	12/31/2999
	LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME	service review.		
	POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF			
	DISEASE UNKNOWN, STAGING IN PROGRESS, NOT			
	LISTED (FOR USE IN A MEDICARE-APPROVED			
	DEMONSTRATION PROJECT)			
9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2008	12/31/2999
	FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE	service review.		
	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			
9147	FIRST 4 HOURS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
914/	or continuous, by any means, guided by the results of	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
	measurements for:respiratory quotient; and/or, urine urea	Policy (CPCP).		
		Policy (CPCP).		
	nitrogen (UUN); and/or, arterial, venous or capillary glucose;			
9147	and/or potassium concentration Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
3141	or continuous, by any means, guided by the results of	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
	measurements for:respiratory quotient; and/or, urine urea	Policy (CPCP).		
	nitrogen (UUN); and/or, arterial, venous or capillary glucose;	rolley (Gror).		
	and/or potassium concentration			
0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
0112	Injection, addeditionab-avwa, 2 mg	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2022	12/31/2333
0174	Injection Jecanemah-irmh 1 mg		9/15/2023	12/31/2999
J 1 T	Injection, localismas-initis, i mg		0, 10,2020	12/01/2000
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	12/31/299

J0177	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0178	Injection, aflibercept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0179	Injection, brolucizumab-dbll, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0202	Injection, alemtuzumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	5/31/2024
	,,g	Submit for Recommended Clinical Review to avoid post-service review.	., .,	
0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	.,,,_,_,	
10219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2022	12/31/2999
02.0	injection, aranginosonados and nigpt, 1 mg	Submit for Recommended Clinical Review to avoid post-service review.	., .,	12/01/2000
0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2008	12/31/2999
	OTHERWISE SPECIFIED	Submit for Recommended Clinical Review to avoid post-service review.	., ., _ 555	12/01/2000
0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2021	12/31/2999
	,,	Submit for Recommended Clinical Review to avoid post-service review.		
0223	Injection, givosiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2024
	,, g, σ	Submit for Recommended Clinical Review to avoid post-service review.		1.2,01,202
0224	Injection, lumasiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2021	12/31/2024
· · · · · · · · · · · · · · · · · · ·	injocaon, ramaciran, c.o mg	Submit for Recommended Clinical Review to avoid post-service review.	17 172021	12/01/2021
0225	Injection, vutrisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2023	12/31/2024
0220	injoodon, vadionan, i mg	Submit for Recommended Clinical Review to avoid post-service review.	17 172020	12/01/2024
0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2024	12/31/2999
0240	injection, remacisivily imig	Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/01/2000
0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
0403	Injection, belatacept, 1 mg	Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2022	12/31/2999
0491	Injection, animolamab-ma, 1 mg	Submit for Recommended Clinical Review to avoid post-service review.	4/ 1/2022	12/31/2999
0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
0317	injection, benializumab, i mg		1/1/2019	12/31/2999
0565	Injection, bezlotoxumab, 10 mg	Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	3/14/2024
0303	injection, beziotoxumab, 10 mg		1/1/2016	3/14/2024
0567	Intention continuous affections	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0040	3/31/2024
10001	Injection, cerliponase alfa, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	3/31/2024
0504	Injustion burgoumab ture 1	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	4/20/2024
0584	Injection, burosumab-twza 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	4/30/2024
0505	INTECTION ON A DOTUMENT OVING A LINET	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
10507	IN JECTION DIMARCHI IN INTOVINE 400 UNITO	Submit for Recommended Clinical Review to avoid post-service review.	4/4/4050	4/04/0004
0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	1/31/2024
0500	INVESTIGATION INCORPORT IN INVESTIGATION AND A ALICE	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0040	4/0.4/000.1
0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2012	1/31/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0600	Injection, edetate calcium disodium, up to 1000 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
J0717	Injection, certolizumab pegol, 1 mg (code may be used for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	6/14/2024
	medicare when drug administered under the direct supervision	Submit for Recommended Clinical Review to avoid post-service review.		
	of a physician, not for use when drug is self administered)			

J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2023	3/14/2024
	use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Submit for Recommended Clinical Review to avoid post-service review.		
0741	Injection, cabotegravir and rilpivirine, 2mg/3mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
775	INJECTION, COLLAGENASE, CLOSTRIDIUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2011	12/31/2999
	HISTOLYTICUM, 0.01 MG	Submit for Recommended Clinical Review to avoid post-service review.		
791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
	, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
0888	Injectin, epoetin beta, 1 microgram, (for non esrd use)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
1203	Injection, cipaglucosidase alfa-atga, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
	, , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2020	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
1001	injustion, toroicon, 1 mg	Submit for Recommended Clinical Review to avoid post-service review.	2, 10,202 1	12/01/2000
1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2021	12/31/2999
.000	Injustion, ormasamas agns, omg	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/01/2000
1306	Injection, inclisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2022	12/31/2999
1000	Injustion, mononan, 1 mg	Submit for Recommended Clinical Review to avoid post-service review.	17 172022	12/01/2000
1325	Injection, epoprostenol, 0. 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
1020	injustion, opoprosionor, o. o mg	Submit for Recommended Clinical Review to avoid post-service review.	17 17 1000	12/01/2000
1411	Injection etranacogene dezanaryovec-drlb per theraneutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2023	12/31/2999
1711	Injection, characogene dezaparvoveo-dnb, per therapedite dose	Submit for Recommended Clinical Review to avoid post-service review.	3/ 1/2023	12/01/2000
1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
1712	nominal 2 x 10^13 vector genomes	Submit for Recommended Clinical Review to avoid post-service review.	2/10/2024	12/01/2000
1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
1410	dose	Submit for Recommended Clinical Review to avoid post-service review.	2/10/2024	12/01/2000
1426	Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2021	12/31/2999
1420	injustion, odolinorosin, ro mg	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/01/2000
1427	Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2021	12/31/2999
1721	injustion, vitolarosti, 10 mg	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2021	12/01/2000
1428	Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	12/31/2999
1420	Injection, etepingen, to mg	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2010	12/01/2000
1429	Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2020	12/31/2999
1420	injustion, goldanison, 10 mg	Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/01/2000
1440	Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2024	12/31/2999
1-7-0	1 Soul Illiotopiota, live - joilli, 1 Illi	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2024	12/01/2000
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2022	12/31/2999
1001	injestion, initialis giobalin (sataquig), 100 mg	Submit for Recommended Clinical Review to avoid post-service review.	11 112022	12/3/1/2333
1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2021	12/31/2999
1004	injection, initialie giobalin (asceniv), 500 mg	Submit for Recommended Clinical Review to avoid post-service review.	4/ 1/2021	12/31/2999
1576	Injection, immune globulin (panzyga), intravenous, non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2023	12/31/2999
13/0			0/1/2023	12/31/2999
	lyophilized (e.g., liquid), 500 mg	Submit for Recommended Clinical Review to avoid post-service review.		

J1632	Injection, brexanolone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
J1675	INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2006	3/14/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	7/15/2023	12/31/2999
		service review.		
J1729	Injection, hydroxyprogesterone caproate, not otherwise	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	7/15/2023	12/31/2999
	specified, 10 mg	service review.		
J1746	Injection, ibalizumab-uiyk, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	3/31/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
1930	INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
J1951	Injection, leuprolide acetate for depot suspension (fensolvi),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2021	12/31/2999
	0.25 mg	Submit for Recommended Clinical Review to avoid post-service review.		
1954	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2278	INJECTION, ZICONOTIDE, 1 MICROGRAM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2006	5/31/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
12329	Injection, ublituximab-xiiy, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2353	Injection, octreotide, depot form for intramuscular injection, 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	mg	Submit for Recommended Clinical Review to avoid post-service review.		
2354	Injection, octreotide, non-depot form for subcutaneous or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	intravenous injection, 25 mcg	Submit for Recommended Clinical Review to avoid post-service review.		
2356	Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
12502	Injection, pasireotide long acting, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	4/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2777	Injection, faricimab-svoa, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
	[,,	Submit for Recommended Clinical Review to avoid post-service review.		,
2778	INJECTION, RANIBIZUMAB, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		12,0.,2000
2782	Injection, avacincaptad pegol, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2024	12/31/2999
	ingonesi, aradinoapiaa pogoi, o. i ing	Submit for Recommended Clinical Review to avoid post-service review.	., .0,202 !	12/01/2000
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	12/31/2999
2.01	Trabolitating o -prioophiate, optimalitie solution, up to 3 mile	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2020	12/01/2009
2796	INJECTION, ROMIPLOSTIM, 10 MICROGRAMS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
2130	INVICTION, NOWIFEOSTIW, IU WICKOGRAWIS		7/ 1/2024	12/31/2999
	, , ,	Submit for Recommended Clinical Review to avoid post-service review.		

J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3111	Injection, romosozumab-aggg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
3121	Injection, testosterone enanthate, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	3/14/2024
	,	Submit for Recommended Clinical Review to avoid post-service review.		
3145	Injection, testosterone undecanoate, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	3/14/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
3241	Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3245	Injection, tildrakizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	5/31/2024
	, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
3247	Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2024	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3393	Injection, betibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
-	7, 7	Submit for Recommended Clinical Review to avoid post-service review.		
3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3396	INJECTION, VERTEPORFIN, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2007	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	.,	1
3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to		7/1/2020	12/31/2999
	5x10^15 vector genomes	Submit for Recommended Clinical Review to avoid post-service review.	., .,	1
3401	Beremagene geperpavec-svdt for topical administration,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Submit for Recommended Clinical Review to avoid post-service review.		1 - 7 - 11 - 11 - 11
3520	Edetate disodium, per 150 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
0020		Submit for Recommended Clinical Review to avoid post-service review.	., .,	12/01/2000
3570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	6/1/2015	12/31/2999
		service review.	0, 1,2010	1.2,01,2000
7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
	, - 3,	Submit for Recommended Clinical Review to avoid post-service review.		1.2,01,2000
7178	Injection, human fibrinogen concentrate, not otherwise specified,		1/1/2013	6/30/2024
	11 mg	Submit for Recommended Clinical Review to avoid post-service review.	., ., 2010	0,00,202
7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
00	(HUMAN), WILATE, 1 I.U. VWF:RCO	Submit for Recommended Clinical Review to avoid post-service review.	., .,	12,01,2000
7311	Injection, fluocinolone acetonide, intravitreal implant (retisert),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/15/2011	12/31/2999
	0.01 mg	Submit for Recommended Clinical Review to avoid post-service review.	5, 10,2011	12/01/2009
7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	12/31/2999
7010	0.01 mg	Submit for Recommended Clinical Review to avoid post-service review.	1, 1,2010	12/01/2000
7351	Injection, bimatoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2020	12/31/2999
1 00 1	injection, binatoprost, intracameral implant, i microgram	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/3/1/2999
7355	Injection, travoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
1 300	mjection, travoprost, intracameral impiant, i microgram		11112024	12/31/2999
17604	ACETYLCYSTEINE, INHALATION SOLUTION,	Submit for Recommended Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
J7604			12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

J7604	ACETYLCYSTEINE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, 0.5 MG	Policy (CPCP).		
607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME.	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, 0.5 MG	Policy (CPCP).		
609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	MG	Policy (CPCP).		
609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	MG	Policy (CPCP).		
610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
0.0	PRODUCT, ADMINISTERED THROUGH DME.	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	CONCENTRATED FORM. 1 MG	Policy (CPCP).		
610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
010	PRODUCT, ADMINISTERED THROUGH DME.	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	CONCENTRATED FORM, 1 MG	Policy (CPCP).		
615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
010	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE,	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	0.5 MG	Policy (CPCP).		
615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
010	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE,	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	0.5 MG	Policy (CPCP).		
622	BECLOMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
022	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
622	BECLOMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
022	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
624	BETAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
024	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
624	BETAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
024	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
021	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/3/1/2999
627	FORM, UP TO 0.5 MG BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
027			12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
2000	FORM, UP TO 0.5 MG	Policy (CPCP).	40/4/0000	40/04/0000
628	BITOLTEROL MESYLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		

J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7629	BITOLTEROL MESYLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7629	BITOLTEROL MESYLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7632	CROMOLYN SODIUM, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	,	Policy (CPCP).		
7632	CROMOLYN SODIUM, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Policy (CPCP).		
7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER 0.25 MILLIGRAM	Policy (CPCP).		
7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER 0.25 MILLIGRAM	Policy (CPCP).		
7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME.	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER MILLIGRAM	Policy (CPCP).		
7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER MILLIGRAM	Policy (CPCP).		
7637	DEXAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7637	DEXAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7638	DEXAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7638	DEXAMETHASONE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, 12 MICROGRAMS	Policy (CPCP).		

J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, 12 MICROGRAMS	Policy (CPCP).		
641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	PER MILLIGRAM	Policy (CPCP).		
641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	PER MILLIGRAM	Policy (CPCP).		
642	GLYCOPYRROLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
642	GLYCOPYRROLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
643	GLYCOPYRROLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
643	GLYCOPYRROLATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
645	IPRATROPIUM BROMIDE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
645	IPRATROPIUM BROMIDE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
647	ISOETHARINE HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
647	ISOETHARINE HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
650	ISOETHARINE HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
650	ISOETHARINE HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
657	ISOPROTERENOL HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
657	ISOPROTERENOL HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
660	ISOPROTERENOL HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		

J7660	ISOPROTERENOL HCL, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7667	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, CONCENTRATED FORM, PER	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	10 MILLIGRAMS	Policy (CPCP).		
7667	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, CONCENTRATED FORM, PER	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	10 MILLIGRAMS	Policy (CPCP).		
7670	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Policy (CPCP).		
7670	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Policy (CPCP).		
7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
7680	TERBUTALINE SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7680	TERBUTALINE SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7681	TERBUTALINE SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7681	TERBUTALINE SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	DME, UNIT DOSE FORM, PER MILLIGRAM	Policy (CPCP).		
7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	CONCENTRATED FORM, PER MILLIGRAM	Policy (CPCP).		
7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER MILLIGRAM	Policy (CPCP).		
7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER MILLIGRAM	Policy (CPCP).		
7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER 300 MILLIGRAMS	Policy (CPCP).		

J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	FORM, PER 300 MILLIGRAMS	Policy (CPCP).		
9029	Intravesical instillation, nadofaragene firadenovec-vncg, per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2023	12/31/2999
	therapeutic dose	Submit for Recommended Clinical Review to avoid post-service review.		
9037	Injection, belantamab mafodontin-blmf, 0.5 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	4/1/2024	12/31/2999
		service review.		
9057	Injection, copanlisib, 1 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	4/1/2024	12/31/2999
		service review.		
9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	9/1/2019	12/31/2999
		service review.		
9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	4/1/2024	12/31/2999
		service review.		
9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2022	12/31/2999
	, , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
9333	Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
	, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9376	Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/15/2024	12/31/2999
	,, _F	Submit for Recommended Clinical Review to avoid post-service review.		1, 5
381	Injection, teplizumab-mzwv, 5 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2023	12/31/2999
	,oonon, topii	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2020	12/01/2000
9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2006	12/31/2999
3000	mozorion, rota imercoopiom, rotalo	Submit for Recommended Clinical Review to avoid post-service review.	2/ 1/2000	12/01/2000
0010	Standard - weight frame motorized/power wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
00.0	Ctariadia Weight Hame Meterized/pewer Wilederlan	Submit for Recommended Clinical Review to avoid post-service review.	17 17 1000	12/01/2000
0011	Standard - weight frame motorized/power wheelchair with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	programmable control parameters for speed adjustment, tremor	Submit for Recommended Clinical Review to avoid post-service review.	17 17 1000	12/01/2000
	dampening, acceleration control and braking	Cubinition recommended comment to avoid post service review.		
0012	Lightweight portable motorized/power wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
0012	Lightweight portable motorized/power wheelendin	Submit for Recommended Clinical Review to avoid post-service review.	17 17 1000	12/01/2000
0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2013	12/31/2999
3010	Oddiom Wotonzod/ Ower Wheelenan Base	Submit for Recommended Clinical Review to avoid post-service review.	17 172010	12/01/2000
0014	Other motorized/power wheelchair base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
5014	Other motorized/power wheelerian base	Submit for Recommended Clinical Review to avoid post-service review.	1/1/1330	12/01/2000
0053	Elevating footrests, articulating (telescoping), each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
0000	Lievating rootiests, articulating (telescoping), each	Submit for Recommended Clinical Review to avoid post-service review.	1/1/1330	12/01/2000
0056	Seat height less than 17 or equal to or greater than 21 for a	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/15/2006	12/31/2999
0000	high strength, lightweight, or ultralightweight wheelchair	Submit for Recommended Clinical Review to avoid post-service review.	3/13/2000	12/01/2000
0108	Wheelchair component or accessory, not otherwise specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
7100	Wheelchair component of accessory, not otherwise specified	Submit for Recommended Clinical Review to avoid post-service review.	1/1/1930	12/31/2999
0455	Infusion pump used for uninterrupted parenteral administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
J-1JJ	of medication, (e. G. , epoprostenol or treprostinol)	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/ 1900	12/3/1/2999
0669		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
0009	Seat/back custom; no dme pdac ver		1/1/1950	12/31/2999
0743	CHOTION DUMP HOME MODEL PORTABLE FOR HOE ON	Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999
0743	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	0/1/2017	12/31/2999
	WOUNDS	Submit for Recommended Clinical Review to avoid post-service review.	l .	

K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2011	12/31/2999
	PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE	Submit for Recommended Clinical Review to avoid post-service review.		1-2-1-1-1-1-1
	INCHES OR LESS	Custinic for Necestimical Common New York to avoid poor convice fortion.		
)746		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2011	12/31/2999
	PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2011	12/01/2000
	THAN 48 SQUARE INCHES	Custilities (Noodiliniesided Cililical Noview to avoid post service feview.		
0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2000	12/01/2000
	POUNDS	Custific for Negotifficiaca Cilifical Neview to avoid post service review.		
0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
7001	PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2000	12/01/2000
0802	POWER OPERATED VEHICLE. GROUP 1 VERY HEAVY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
0002	DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2000	12/3/1/2999
0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
1000	· · · · · · · · · · · · · · · · · · ·	l	10/1/2000	12/31/2999
	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Submit for Recommended Clinical Review to avoid post-service review.		
1907	POUNDS	MD Critorio, Propoduro (comico reviewed a seriest Madical Palia, Critaria	10/1/2000	10/04/0000
0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.	10/1/0000	10/04/0000
808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.		
812	POWER OPERATED VEHICLE, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CLASSIFIED	Submit for Recommended Clinical Review to avoid post-service review.		
813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT AND BACK, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS			
)814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Submit for Recommended Clinical Review to avoid post-service review.		
	AND INCLUDING 300 POUNDS	'		
815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS			
0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
70.10	CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2000	12/01/2000
	INCLUDING 300 POUNDS	Custinic for Necestimical Common New York to avoid poor convice fortion.		
0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Submit for Recommended Clinical Review to avoid post-service review.	10, 1, 2000	12,01/2000
	TO AND INCLUDING 300 POUNDS	Cashin 15. Recommended Chimour Review to avoid post-service review.		
)821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
/UZ I	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Submit for Recommended Clinical Review to avoid post-service review.	10/1/2000	12/3/1/233
	AND INCLUDING 300 POUNDS	Toubilition Neconfinenced Chilical Neview to avoid post-service review.		
822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
1022			10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
(0000	INCLUDING 300 POUNDS	MD Official December for the section of the Public Co.	40/4/0000	40/04/0000
0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS			
0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	301 TO 450 POUNDS			I

K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.		
<0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	451 TO 600 POUNDS			
(0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600	Submit for Recommended Clinical Review to avoid post-service review.		
	POUNDS			
(0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	601 POUNDS OR MORE			
< 0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601	Submit for Recommended Clinical Review to avoid post-service review.		
	POUNDS OR MORE			
(0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS	· ·		
(0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	· ·		
(0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
(0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY 301 TO 450 POUNDS			
(0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SINGLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	· ·		
0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SINGLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
	PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE			
0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	· ·		
0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS	·		
(0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
(0848		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS	1		

K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS	'		
(0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	301 TO 450 POUNDS	· ·		
(0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Submit for Recommended Clinical Review to avoid post-service review.		
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	451 TO 600 POUNDS			
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO	Submit for Recommended Clinical Review to avoid post-service review.		
	600 POUNDS			
< 0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	601 POUNDS OR MORE			
< 0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601	Submit for Recommended Clinical Review to avoid post-service review.		
	POUNDS OR MORE			
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS			
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY 301 TO 450 POUNDS			
< 0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SINGLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS			
(0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
(0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
(0004	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	INDOM - B	40/4/0000	10/04/2000
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
	PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE			
(0868		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS			

K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Submit for Recommended Clinical Review to avoid post-service review.		
	INCLUDING 300 POUNDS	'		
(0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	301 TO 450 POUNDS	'		
(0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Submit for Recommended Clinical Review to avoid post-service review.		
	451 TO 600 POUNDS			
(0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT	Submit for Recommended Clinical Review to avoid post-service review.		
	CAPACITY UP TO AND INCLUDING 300 POUNDS			
0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	SINGLE POWER OPTION, SLING/SOLID SEAT/BACK,	Submit for Recommended Clinical Review to avoid post-service review.		
	PATIENT WEIGHT 451 TO 600 POUNDS			
0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS			
(0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP	· · · · · · · · · · · · · · · · · · ·		
	TO AND INCLUDING 300 POUNDS			
(0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY 301 TO 450 POUNDS			
(0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS			
(0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT	Submit for Recommended Clinical Review to avoid post-service review.		
	WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS			
(0899	Power mobile device; no dme pdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2006	12/31/2999
	<u>'</u>	Submit for Recommended Clinical Review to avoid post-service review.		
(1004	Low frequency ultrasonic diathermy treatment device for home		12/1/2020	12/31/2999
	luse	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1004	Low frequency ultrasonic diathermy treatment device for home	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	use	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
	component, single or double upright(s), knee joints any type,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	with or without ankle joints any type, includes all components	Policy (CPCP).		

K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
	component, single or double upright(s), knee joints any type,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	Policy (CPCP).		
1027	Oral device/appliance used to reduce upper airway collapsibility,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2021	7/31/2024
	without fixed mechanical hinge, custom fabricated, includes	Submit for Recommended Clinical Review to avoid post-service review.		
	fitting and adjustment			
(1030	External recharging system for battery (internal) for use with	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2022	12/31/2999
	implanted cardiac contractility modulation generator,	Submit for Recommended Clinical Review to avoid post-service review.		
	replacement only			
1036	Supplies and accessories (e.g., transducer) for low frequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	ultrasonic diathermy treatment device, per month	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(1036	Supplies and accessories (e.g., transducer) for low frequency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	ultrasonic diathermy treatment device, per month	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(1037	Docking station for use with oral device/appliance used to	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	reduce upper airway collapsibility	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(1037	Docking station for use with oral device/appliance used to	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
	reduce upper airway collapsibility	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
1037	Docking station for use with oral device/appliance used to	· · · · · · · · · · · · · · · · · · ·	9/15/2024	9/30/2024
	reduce upper airway collapsibility	Submit for Recommended Clinical Review to avoid post-service review.		12/2/22
.1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	circumferential frame with anterior and posterior rigid pads, custom fabricated	Submit for Recommended Clinical Review to avoid post-service review.		
1834	Knee orthosis, without knee joint, rigid, custom-fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
.1840	Knee orthosis, derotation, medial-lateral, anterior cruciate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	ligament, custom fabricated	Submit for Recommended Clinical Review to avoid post-service review.		
_1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	WITH ADJUSTABLE FLEXION AND EXTENSION JOINT	Submit for Recommended Clinical Review to avoid post-service review.		
	(UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND			
	ROTATION CONTROL, WITH OR WITHOUT			
	VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED			
1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	WITH ADJUSTABLE FLEXION AND EXTENSION JOINT	Submit for Recommended Clinical Review to avoid post-service review.		
	(UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND			
	ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS			
2010	ADJUSTMENT, CUSTOM FABRICATED		4/4/4050	10/01/0000
3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
3060	Foot, arch support, removable, premolded, longitudinal/	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	metatarsal, each	service review.		
.5610	Addition to lower extremity, endoskeletal system, above knee,	,	6/1/2006	12/31/2999
	hydracadence system	Submit for Recommended Clinical Review to avoid post-service review.		

-5611	Addition to lower extremity, endoskeletal system, above knee -	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	knee disarticulation, 4 bar linkage, with friction swing phase	Submit for Recommended Clinical Review to avoid post-service review.		
	control			
5613	Addition to lower extremity, endoskeletal system, above knee-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	knee disarticulation, 4 bar linkage, with hydraulic swing phase	Submit for Recommended Clinical Review to avoid post-service review.		
	control			
5614	Addition to lower extremity, exoskeletal system, above knee-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	knee disarticulation, 4 bar linkage, with pneumatic swing phase	Submit for Recommended Clinical Review to avoid post-service review.		
	control	·		
5615	Addition, endoskeletal knee-shin system, 4 bar linkage or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	multiaxial, fluid swing and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5616	Addition to lower extremity, endoskeletal system, above knee,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	universal multiplex system, friction swing phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5620	Addition to lower extremity, test socket, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	·	Submit for Recommended Clinical Review to avoid post-service review.		
5624	Addition to lower extremity, test socket, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5629	Addition to lower extremity, below knee, acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5631	Addition to lower extremity, above knee or knee disarticulation,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	acrylic socket	Submit for Recommended Clinical Review to avoid post-service review.		
638	Addition to lower extremity, below knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Submit for Recommended Clinical Review to avoid post-service review.		
5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Submit for Recommended Clinical Review to avoid post-service review.		
5640	Addition to lower extremity, knee disarticulation, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	, ,, , ,, , ,, , ,, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	,, ,, , ,, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	,, ,, , ,, , ,	Submit for Recommended Clinical Review to avoid post-service review.		
5645	Addition to lower extremity, below knee, flexible inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	external frame	Submit for Recommended Clinical Review to avoid post-service review.		1
5646	Addition to lower extremity, below knee, air, fluid, gel or equal,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	cushion socket	Submit for Recommended Clinical Review to avoid post-service review.		
647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	,, , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
5648	Addition to lower extremity, above knee, air, fluid, gel or equal,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
70.0	cushion socket	Submit for Recommended Clinical Review to avoid post-service review.	0, 1, 2000	1.2,0.,2000
5651	Addition to lower extremity, above knee, flexible inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	external frame	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	, 0 ., _ 000
652	Addition to lower extremity, suction suspension, above knee or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	knee disarticulation socket	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	1.2,0.,2000
670	Addition to lower extremity, below knee, molded supracondylar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	suspension ('pts' or similar)	Submit for Recommended Clinical Review to avoid post-service review.	5/ 1/2000	12,01,2000
5676	Additions to lower extremity, below knee, knee joints, single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
3373	axis, pair	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12/01/2000
5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	I CUSTOIN SHADEU DIVIEULIVE GUVEL. DEIUW NIICE	TIVIL CITICITA. I TOCCUUI C/3CI VICE I CVICWEU AUAIITSI IVICUICAI FUIICV CITICITA.	10/1/2000	12/01/2000

_5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
.5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5710	Addition, exoskeletal knee-shin system, single axis, manual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	lock	Submit for Recommended Clinical Review to avoid post-service review.		
5711	Additions exoskeletal knee-shin system, single axis, manual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	lock, ultra-light material	Submit for Recommended Clinical Review to avoid post-service review.		
5712	Addition, exoskeletal knee-shin system, single axis, friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing and stance phase control (safety knee)	Submit for Recommended Clinical Review to avoid post-service review.		
5714	Addition, exoskeletal knee-shin system, single axis, variable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	friction swing phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5716	Addition, exoskeletal knee-shin system, polycentric, mechanical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	stance phase lock	Submit for Recommended Clinical Review to avoid post-service review.		
718	Addition, exoskeletal knee-shin system, polycentric, friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5722	Addition, exoskeletal knee-shin system, single axis, pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing, friction stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5724	Addition, exoskeletal knee-shin system, single axis, fluid swing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	phase control	Submit for Recommended Clinical Review to avoid post-service review.		
726	Addition, exoskeletal knee-shin system, single axis, external	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
0	joints fluid swing phase control	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12/01/2000
728	Addition, exoskeletal knee-shin system, single axis, fluid swing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
20	and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/01/2000
780	Addition, exoskeletal knee-shin system, single axis,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
7700	pneumatic/hydra pneumatic swing phase control	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
5785	Addition, exoskeletal system, below knee, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
7703	(titanium, carbon fiber or equal)	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
5790	Addition, exoskeletal system, above knee, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
0790		,	0/1/2006	12/31/2999
5795	(titanium, carbon fiber or equal)	Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
0/95	Addition, exoskeletal system, hip disarticulation, ultra-light	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	0/1/2006	12/31/2999
-040	material (titanium, carbon fiber or equal)	Submit for Recommended Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
810	Addition, endoskeletal knee-shin system, single axis, manual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	lock	Submit for Recommended Clinical Review to avoid post-service review.		
5811	Addition, endoskeletal knee-shin system, single axis, manual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	lock, ultra-light material	Submit for Recommended Clinical Review to avoid post-service review.		
812	Addition, endoskeletal knee-shin system, single axis, friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing and stance phase control (safety knee)	Submit for Recommended Clinical Review to avoid post-service review.		
5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing phase control, mechanical stance phase lock	Submit for Recommended Clinical Review to avoid post-service review.		
5816	Addition, endoskeletal knee-shin system, polycentric,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	mechanical stance phase lock	Submit for Recommended Clinical Review to avoid post-service review.		
818	Addition, endoskeletal knee-shin system, polycentric, friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing, and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
822	Addition, endoskeletal knee-shin system, single axis, pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing, friction stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5824	Addition, endoskeletal knee-shin system, single axis, fluid swing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5826	Addition, endoskeletal knee-shin system, single axis, hydraulic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	swing phase control, with miniature high activity frame	Submit for Recommended Clinical Review to avoid post-service review.		

L5828	· _ · _ · _ · _ · _ · _ ·	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5830	Addition, endoskeletal knee-shin system, single axis,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	pneumatic/ swing phase control	Submit for Recommended Clinical Review to avoid post-service review.		
840	Addition, endoskeletal knee/shin system, 4-bar linkage or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	multiaxial, pneumatic swing phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2024	12/31/2999
	swing, and stance phase control	Submit for Recommended Clinical Review to avoid post-service review.		
5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	STANCE EXTENSION, DAMPENING FEATURE, WITH OR	Submit for Recommended Clinical Review to avoid post-service review.		
	WITHOUT ADJUSTABILITY			
.5856	ADDITION TO LOWER EXTREMITY PROSTHESIS,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2007	12/31/2999
	ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR	Submit for Recommended Clinical Review to avoid post-service review.		
	CONTROL FEATURE, SWING AND STANCE PHASE,	· ·		
	INCLUDES ELECTRONIC SENSOR(S), ANY TYPE			
	(),			
.5858	ADDITION TO LOWER EXTREMITY PROSTHESIS,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2007	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES			
	ELECTRONIC SENSOR(S), ANY TYPE			
.5859	Addition to lower extremity prosthesis, endoskeletal knee-shin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2013	12/31/2999
	system, powered and programmable flexion/extension assist	Submit for Recommended Clinical Review to avoid post-service review.	., ., 20.10	.2/0./2000
	control, includes any type motor(s)	Cashine for recommended climical review to avoid poor corving forton.		
-5926	Addition to lower extremity prosthesis, endoskeletal, knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
	• • • • • • • • • • • • • • • • • • • •	Submit for Recommended Clinical Review to avoid post-service review.	07.07202.	.2/01/2000
	unit, any type			
-5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
	JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION	Submit for Recommended Clinical Review to avoid post-service review.	0/2 //2012	12/01/2000
	CONTROL, WITH OR WITHOUT FLEXION AND/OR	Cashin for recommended climical review to avoid post corrido review.		
	EXTENSION CONTROL			
.5962	Addition, endoskeletal system, below knee, flexible protective	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
.0002	outer surface covering system	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/01/2000
.5964	Addition, endoskeletal system, above knee, flexible protective	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	outer surface covering system	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12,01,2000
.5966	Addition, endoskeletal system, hip disarticulation, flexible	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	protective outer surface covering system	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12,01,2000
.5968	Addition to lower limb prosthesis, multiaxial ankle with swing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/15/2015	12/31/2999
	phase active dorsiflexion feature	Submit for Recommended Clinical Review to avoid post-service review.	1, 10,2010	12,31,2000
5969	Addition, endoskeletal ankle-foot or ankle system, power assist,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
	includes any type motor(s)	Submit for Recommended Clinical Review to avoid post-service review.	., ,,,2011	12/31/2000
.5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
.0070	7 in 13 Wor Oxformity produced by 100t, external rect, 3doi 100t	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12,01,2009
.5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
.0072	7 th 15 West extremitly prostriceses, 100t, flexible Roel	Submit for Recommended Clinical Review to avoid post-service review.	0/ 1/2000	12/01/2000
.5973	ENDOSKELETAL ANKLE FOOT SYSTEM,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
-0813	■		11/1/2019	12/31/2999
	MICROPROCESSOR CONTROLLED FEATURE,	Submit for Recommended Clinical Review to avoid post-service review.		
	DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL,			
	INCLUDES POWER SOURCE			

L5974	All lower extremity prostheses, foot, single axis ankle/foot		6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5976	All lower extremity prostheses, energy storing foot (seattle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	carbon copy ii or equal)	Submit for Recommended Clinical Review to avoid post-service review.		
5978	All lower extremity prostheses, foot, multiaxial ankle/foot		6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5979	All lower extremity prosthesis, multi-axial ankle, dynamic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
	response foot, one piece system	Submit for Recommended Clinical Review to avoid post-service review.		
.5980	All lower extremity prostheses, flex foot system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
.5981	All lower extremity prostheses, flex-walk system or equal		6/1/2006	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5982	All exoskeletal lower extremity prostheses, axial rotation unit		6/1/2006	12/31/2999
0002	7 III ONGONOICIAN ICINO ONII CININI, PICCONICCO, ANII ANII CININI	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12/01/2000
5984	All endoskeletal lower extremity prosthesis, axial rotation unit,		6/1/2006	12/31/2999
	with or without adjustability	Submit for Recommended Clinical Review to avoid post-service review.	5, .,2000	/0 //2000
5985	All endoskeletal lower extremity prostheses, dynamic prosthetic		6/1/2006	12/31/2999
.0000	pylon	Submit for Recommended Clinical Review to avoid post-service review.	0, 1,2000	12/01/2000
5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2006	12/31/2999
3900	legual)	Submit for Recommended Clinical Review to avoid post-service review.	0/1/2000	12/31/2999
5987	All lower extremity prosthesis, shank foot system with vertical		6/1/2006	12/31/2999
3907			0/1/2000	12/31/2999
5004	loading pylon	Submit for Recommended Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
5991		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	prosthetic connector	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
5991	* *	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
	prosthetic connector	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
6026	Transcarpal/metacarpal or partial hand disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
	prosthesis, external power, self-suspended, inner socket with	Submit for Recommended Clinical Review to avoid post-service review.		
	removable forearm section, electrodes and cables, two			
	batteries, charger, myoelectric control of terminal device,			
	excludes terminal device(s)		1	
6611	ADDITION TO UPPER EXTREMITY PROSTHESIS,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	Submit for Recommended Clinical Review to avoid post-service review.	1	
6621	UPPER EXTREMITY PROSTHESIS ADDITION,		4/1/2009	12/31/2999
	FLEXION/EXTENSION WRIST WITH OR WITHOUT	Submit for Recommended Clinical Review to avoid post-service review.		
	FRICTION, FOR USE WITH EXTERNAL POWERED		1	
6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2012	12/31/2999
	CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS,	Submit for Recommended Clinical Review to avoid post-service review.		.2/01/2000
	ANY GRASP PATTERN OR COMBINATION OF GRASP	2.2	1	
	PATTERNS, INCLUDES MOTOR(S)		1	
6882	Microprocessor control feature, addition to upper limb prosthetic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
0002	terminal device	Submit for Recommended Clinical Review to avoid post-service review.	7/ 1/2003	12/3/1/2999
6020	Wrist disarticulation, external power, self-suspended inner		4/1/2009	12/31/2999
6920			4/ 1/2009	12/31/2999
	socket, removable forearm shell, otto bock or equal, switch,	Submit for Recommended Clinical Review to avoid post-service review.	1	
	cables, two batteries and one charger, switch control of terminal		1	
	device			

L6925	Wrist disarticulation, external power, self-suspended inner	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	Submit for Recommended Clinical Review to avoid post-service review.		
6930	Below elbow, external power, self-suspended inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	removable forearm shell, otto bock or equal switch, cables, two	Submit for Recommended Clinical Review to avoid post-service review.		
	batteries and one charger, switch control of terminal device			
6935	Below elbow, external power, self-suspended inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	removable forearm shell, otto bock or equal electrodes, cables,	Submit for Recommended Clinical Review to avoid post-service review.		
	two batteries and one charger, myoelectronic control of terminal			
00.10	device	NDO'S S D I I I I I I I I I I I I I I I I I	4/4/0000	10/01/0000
6940	Elbow disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	removable humeral shell, outside locking hinges, forearm, otto	Submit for Recommended Clinical Review to avoid post-service review.		
	bock or equal switch, cables, two batteries and one charger,			
6945	switch control of terminal device Elbow disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
0040	removable humeral shell, outside locking hinges, forearm, otto	Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/3/1/2333
	bock or equal electrodes, cables, two batteries and one charger,			
	myoelectronic control of terminal device			
6950	Above elbow, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	humeral shell, internal locking elbow, forearm, otto bock or	Submit for Recommended Clinical Review to avoid post-service review.	., .,	12/01/2000
	equal switch, cables, two batteries and one charger, switch			
	control of terminal device			
6955	Above elbow, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	humeral shell, internal locking elbow, forearm, otto bock or	Submit for Recommended Clinical Review to avoid post-service review.		
	equal electrodes, cables, two batteries and one charger,	·		
	myoelectronic control of terminal device			
6960	Shoulder disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	Submit for Recommended Clinical Review to avoid post-service review.		
	mechanical elbow, forearm, otto bock or equal switch, cables,			
	two batteries and one charger, switch control of terminal device		444,0000	10/04/0000
6965	Shoulder disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	Submit for Recommended Clinical Review to avoid post-service review.		
	mechanical elbow, forearm, otto bock or equal electrodes,			
	cables, two batteries and one charger, myoelectronic control of			
6970	terminal device Interscapular-thoracic, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
5970	removable shoulder shell, shoulder bulkhead, humeral section,	Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
	mechanical elbow, forearm, otto bock or equal switch, cables,	oubtilit for Necontinended Cililical Neview to avoid post-service review.		
	two batteries and one charger, switch control of terminal device			
3975	Interscapular-thoracic, external power, molded inner socket,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
•	removable shoulder shell, shoulder bulkhead, humeral section,	Submit for Recommended Clinical Review to avoid post-service review.		1.2,51,2000
	mechanical elbow, forearm, otto bock or equal electrodes,	Table 100 100 100 100 100 100 100 100 100 10		
	cables, two batteries and one charger, myoelectronic control of			
	terminal device			
7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	CONTROLLED, ADULT	Submit for Recommended Clinical Review to avoid post-service review.		
7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	CONTROLLED, PEDIATRIC	Submit for Recommended Clinical Review to avoid post-service review.		

_7009	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
_7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED		4/4/0000	12/31/2999
.7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC	Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
7045			4/1/2009	12/31/2999
	ONTROLLED, PEDIATRIC	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
7170	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
7180	Electronic albow microprocessor acquential control of albow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
100	Electronic elbow, microprocessor sequential control of elbow and terminal device		4/1/2009	12/31/2999
7404		Submit for Recommended Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
7181	ELECTRONIC ELBOW, MICROPROCESSOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	Submit for Recommended Clinical Review to avoid post-service review.		
7185	Electronic elbow, adolescent, variety village or equal, switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	controlled	Submit for Recommended Clinical Review to avoid post-service review.		
7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
7190	Electronic elbow, adolescent, variety village or equal,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
-	myoelectronically controlled	Submit for Recommended Clinical Review to avoid post-service review.		
'191	Electronic elbow, child, variety village or equal,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
101	myoelectronically controlled	Submit for Recommended Clinical Review to avoid post-service review.	1/1/2000	12/01/2000
259	Electronic wrist rotator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
239	Liectionic what rotator, any type	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2013	12/31/2999
360	Six volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
300	Six voit battery, each	Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
'362	Battery charger, six volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
002	Battery sharger, elix veit, each	Submit for Recommended Clinical Review to avoid post-service review.	17 172000	12/01/2000
7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
	,	Submit for Recommended Clinical Review to avoid post-service review.		
7366	Battery charger, twelve volt, each		4/1/2009	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Submit for Recommended Clinical Review to avoid post-service review.		
7367	Lithium ion battery, rechargeable, replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		12/01/2000
'368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2007	12/31/2999
000	ETTHORITOR BY THE ETT OF WITCHEST, THE PETTOLINE TO THE	Submit for Recommended Clinical Review to avoid post-service review.	1710/2001	12/01/2000
3603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
5000	syringe, includes shipping and necessary supplies	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2024	12/01/2000
	syninge, includes shipping and necessary supplies	Policy (CPCP).		
3603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2024	12/31/2999
5000	syringe, includes shipping and necessary supplies	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/10/2024	12/01/2000
	syringe, includes shipping and necessary supplies	Policy (CPCP).		
3603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	5/14/2024
,000	syringe, includes shipping and necessary supplies	Submit for Recommended Clinical Review to avoid post-service review.	, ., 2010	0/ 1-1/2027
604	INJECTABLE BULKING AGENT.	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2009	12/31/2999
0004	,	, ,	1/ 1/2009	12/31/2999
	DEXTRANOMER/HYALURONIC ACID COPOLYMER	Submit for Recommended Clinical Review to avoid post-service review.		
	IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING			
2005	AND NECESSARY SUPPLIES	FILL December (combined and resimble constitutions)	40/4/0000	40/04/0000
3605			12/1/2020	12/31/2999
	implant, anal canal, 1 ml, includes shipping and necessary	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	supplies	Policy (CPCP).		

_8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	implant, anal canal, 1 ml, includes shipping and necessary	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	supplies	Policy (CPCP).		
606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/1/2007	12/31/2999
	syringe, includes shipping and necessary supplies	Submit for Recommended Clinical Review to avoid post-service review.		
607	Injectable bulking agent for vocal cord medialization, 0.1 ml,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2016	12/31/2999
	includes shipping and necessary supplies	Submit for Recommended Clinical Review to avoid post-service review.		
608	Miscellaneous external component, supply or accessory for use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	with the argus ii retinal prosthesis system	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
608	Miscellaneous external component, supply or accessory for use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	9/14/2024
	with the argus ii retinal prosthesis system	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
609	ARTIFICIAL CORNEA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2015	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
312	Aqueous shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
678	Electrical stimulator supplies (external) for use with implantable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2023	12/31/2999
	neurostimulator, per month	Submit for Recommended Clinical Review to avoid post-service review.		
679	Implantable neurostimulator, pulse generator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
	miplaniable near estimates, panes generales, any type	Submit for Recommended Clinical Review to avoid post-service review.	.,.,	.2,0.,2000
680	Implantable neurostimulator electrode, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.	.,.,	.2,0.,2000
681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2023	12/31/2999
	IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR	Submit for Recommended Clinical Review to avoid post-service review.	.,,2020	.2,0.,2000
	PULSE GENERATOR, REPLACEMENT ONLY	Cashin for Accommonaca chinear Action to avoid post cortice fortier.		
682	Implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/19/2022	12/31/2999
	,	Submit for Recommended Clinical Review to avoid post-service review.		
683	Radiofrequency transmitter (external) for use with implantable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2023	12/31/2999
	neurostimulator radiofrequency receiver	Submit for Recommended Clinical Review to avoid post-service review.		1.2.0
685	Implantable neurostimulator pulse generator, single array,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
	rechargeable, includes extension	Submit for Recommended Clinical Review to avoid post-service review.		1.2,0.1,200
686	Implantable neurostimulator pulse generator, single array, non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
000	rechargeable, includes extension	Submit for Recommended Clinical Review to avoid post-service review.	17 172022	12/01/2000
687	Implantable neurostimulator pulse generator, dual array,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
001	rechargeable, includes extension	Submit for Recommended Clinical Review to avoid post-service review.	17 172022	12/01/2000
688	Implantable neurostimulator pulse generator, dual array, non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
000	rechargeable, includes extension	Submit for Recommended Clinical Review to avoid post-service review.	17 172022	12/01/2000
689	EXTERNAL RECHARGING SYSTEM FOR BATTERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2023	12/31/2999
003	(INTERNAL) FOR USE WITH IMPLANTABLE	Submit for Recommended Clinical Review to avoid post-service review.	7710/2020	12/01/2000
	NEUROSTIMULATOR, REPLACEMENT ONLY	Cashin for Accommended Chillean Acview to avoid post-service review.		
694	Auditory osseointegrated device, transducer/actuator,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2018	12/31/2999
004	replacement only, each	Submit for Recommended Clinical Review to avoid post-service review.	1/ 1/2010	12/31/2333
695	EXTERNAL RECHARGING SYSTEM FOR BATTERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/19/2022	12/31/2999
บฮอ			9/ 19/2022	12/31/2999
	(EXTERNAL) FOR USE WITH IMPLANTABLE	Submit for Recommended Clinical Review to avoid post-service review.		
600	NEUROSTIMULATOR, REPLACEMENT ONLY	MD Criteria: Presedure/service reviewed against Madical Delicy Criteria	1/1/2010	10/21/2000
698		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
	artificial heart system	Submit for Recommended Clinical Review to avoid post-service review.	L	

L8701	Powered upper extremity range of motion assist device, elbow,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2019	12/31/2999
	wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	Submit for Recommended Clinical Review to avoid post-service review.		
_8702	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		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		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
л0241	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	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		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		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		6/1/2023	12/31/2999

M0244	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	imdevimab includes infusion or injection, and post	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	administration monitoring in the home or residence; this	Policy (CPCP).		
	includes a beneficiary's home that has been made provider-			
	based to the hospital during the covid-19 public health			
	emergency			
0245	Intravenous infusion, bamlanivimab and etesevimab, includes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	infusion and post administration monitoring	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0245	Intravenous infusion, bamlanivimab and etesevimab, includes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	infusion and post administration monitoring	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0246	Intravenous infusion, bamlanivimab and etesevimab, includes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	infusion and post administration monitoring in the home or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	residence; this includes a beneficiary's home that has been	Policy (CPCP).		
	made provider based to the hospital during the covid 19 public			
	health emergency			
0246	Intravenous infusion, bamlanivimab and etesevimab, includes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	infusion and post administration monitoring in the home or	review. Check EIU policy, which is one of our Clinical Payment and Coding		
	residence; this includes a beneficiary's home that has been	Policy (CPCP).		
	made provider based to the hospital during the covid 19 public	, (•. •. /-		
	health emergency			
0300	Iv chelation therapy (chemical endarterectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
	37	Submit for Recommended Clinical Review to avoid post-service review.		
0301	Fabric wrapping of abdominal aneurysm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
2029	Congo red, blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/24/2012	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
9603	Travel allowance one way in connection with medically	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	necessary laboratory specimen collection drawn from home	service review.		
	bound or nursing home bound patient; prorated miles actually			
	travelled			
9604	Travel allowance one way in connection with medically	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	necessary laboratory specimen collection drawn from home	service review.		
	bound or nursing home bound patient; prorated trip charge.			
0035	Cardiokymography	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	, , ,	service review.		
0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
	, , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
Q02-10	injection, eachivillas and infactinas, eco mg	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2020	12/01/2000
		Policy (CPCP).		
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
202 10	injection, each vinias and iniacvinias, 2 100 mg	review. Check EIU policy, which is one of our Clinical Payment and Coding	G/ 1/2020	12/01/2000
		Policy (CPCP).		
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
20244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
20244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
20245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	6/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0482	Microprocessor control unit for use with electric/pneumatic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
	combination ventricular assist device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.		
0485	Monitor control cable for use with electric ventricular assist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
	device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.		
20487	Leads (pneumatic/electrical) for use with any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
	electric/pneumatic ventricular assist device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.		
20490	Emergency power source for use with electric ventricular assist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
	device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.		
20492	Emergency power supply cable for use with electric ventricular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
	assist device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.	10/1/0005	10/01/0000
20494	Emergency hand pump for use with electric or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
20500	electric/pneumatic ventricular assist device, replacement only	Submit for Recommended Clinical Review to avoid post-service review.	40/4/0005	10/01/0000
0502	Mobility cart for pneumatic ventricular assist device,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
20504	replacement only	Submit for Recommended Clinical Review to avoid post-service review.	40/4/0005	40/04/0000
0504	Power adapter for pneumatic ventricular assist device,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2005	12/31/2999
0540	replacement only, vehicle type	Submit for Recommended Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
0510	PHARMACY SUPPLY FEE FOR INITIAL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
	IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH	service review.		
0511	FOLLOWING transPLANT PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
(0311	ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR	Inon Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	1/1/2006	12/31/2999
	THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	SCIVICE IEVIEW.		
0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2006	12/31/2999
(UJ 1Z	immunosuppressive drug(s); for a subsequent prescription in a	Inon Covered. Procedure/service not covered by the Plan. Not subject to pre- Iservice review.	1/1/2000	12/31/2999
	30-day period	SCIVICE ICVICW.		
20516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/2/2024	12/31/2999
20010	approved prescription oral drug, per 30-days	service review.	1/2/2024	12/31/2999
20517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/2/2024	12/31/2999
20017		·	1/2/2024	12/31/2999
	approved prescription oral drug, per 60-days	service review.		

Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/2/2024	12/31/2999
	approved prescription oral drug, per 90-days	service review.		
2026	INJECTION, RADIESSE, 0.1 ML		8/15/2013	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
Q2028	Injection, sculptra, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2014	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19	,	4/1/2018	12/31/2999
	car positive viable t cells, including leukapheresis and dose	Submit for Recommended Clinical Review to avoid post-service review.		
	preparation procedures, per therapeutic dose			
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells,	i ,	7/1/2011	12/31/2999
	including leukapheresis and dose preparation procedures, per therapeutic dose	Submit for Recommended Clinical Review to avoid post-service review.		
22049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	4/1/2024	12/31/2999
	Lipodox, 10 mg	service review.		
Q2052	Services, supplies, and accessories used in the home for the	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	4/1/2014	12/31/2999
	administration of intravenous immune globulin (ivig)	service review.		
22053	Brexucabtagene autoleucel, up to 200 million autologous anti-	3	4/1/2021	12/31/2999
	cd19 car positive viable t cells, including leukapheresis and	Submit for Recommended Clinical Review to avoid post-service review.		
	dose preparation procedures, per therapeutic dose			
22054	Lisocabtagene maraleucel, up to 110 million autologous anti-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2021	12/31/2999
	cd19 car-positive viable t cells, including leukapheresis and	Submit for Recommended Clinical Review to avoid post-service review.		
	dose preparation procedures, per therapeutic dose			
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
	leukapheresis and dose preparation procedures, per therapeutic			
	dose			
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2022	12/31/2999
	maturation antigen (bcma) directed car-positive t cells, including	· ·		
	leukapheresis and dose preparation procedures, per therapeutic			
24000	dose		4/4/0007	10/01/0000
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED,		1/1/2007	12/31/2999
	PART B DRUG COMPETITIVE ACQUISITION PROGRAM	service review.		
24400	(CAP)	MD Ottoda December (combined to the control of the	44/45/0000	40/04/0000
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
24404	ADUCDAE DED COLLADE CENTIMETED	Submit for Recommended Clinical Review to avoid post-service review.	44/45/2020	40/04/0000
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
24400	OACIC WOLIND MATRIX DED COLLADE CENTRACTED	Submit for Recommended Clinical Review to avoid post-service review.	44/45/0000	40/04/0000
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

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).		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

Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
24115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4121	THERASKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	6/30/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4121	THERASKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	6/30/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4121	THERASKIN, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
4122	Dermacell, dermacell awm or dermacell awm porous, per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2021	12/31/2999
	square centimeter	Submit for Recommended Clinical Review to avoid post-service review.		
4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	CENTIMETER	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	CENTIMETER	review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	E/1E/2021	12/31/2999
34123	ANTINOPELA, PEN SQUANE CENTIVIETEN	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 13/2021	12/31/2999
		Policy (CPCP).		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.1107	TALVAMED DED COLLADE CENTIMETED	Policy (CPCP).	5/45/0004	40/04/0000
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4127	TALYMED, PER SQUARE CENTIMETER	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
34121	TALTIMED, FER SQUARE CENTIMETER	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/ 13/2021	12/31/2999
		Policy (CPCP).		
Q4128	Flex hd, or allopatch hd, per square centimeter		11/15/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4132	Grafix core and grafixpl core, per square centimeter	,	8/15/2021	12/31/2999
0.1100		Submit for Recommended Clinical Review to avoid post-service review.	011510001	40/04/0000
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square		8/15/2021	12/31/2999
	centimeter	Submit for Recommended Clinical Review to avoid post-service review.		

Q4134	Hmatrix per square centimeter	FILE Procedure/service not reimbursed by the Plan. Not subject to pre-service	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
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).		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

Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4140	Biodfence, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4140	Biodfence, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4142	Xcm biologic tissue matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4142	Xcm biologic tissue matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24445	E 15 11 11 1	Policy (CPCP).	40/4/0000	10/04/0000
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24445	Fulfic total August	Policy (CPCP).	40/4/0000	40/04/0000
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4146	Tanais, nan anyana aantinatan	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	E/4E/2024	12/31/2999
24140	Tensix, per square centimeter		5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24146	Tongiy nor organiza continutor	Policy (CPCP).	E/4E/0004	12/31/2999
Q4146	Tensix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24447	Anabita at anabita at my an anabita at formation will be at the same of the sa	Policy (CPCP).	E/4E/0004	40/04/0000
Q4147	Architect, architect px, or architect fx, extracellular matrix, per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4147	Architect, architect px, or architect fx, extracellular matrix, per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
44.40	Near and the many and it an alarity and the man arrange	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	40/4/0000	12/31/2999
4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square		12/1/2020	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4151	Amnioband or guardian, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
(4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4153	Dermavest and plurivest, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4153	Dermavest and plurivest, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
24155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, i i	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	3 - 71	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	3 - 71	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2022	12/31/2999
	7,1	Submit for Recommended Clinical Review to avoid post-service review.		
(4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1
		Policy (CPCP).		
24160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1
		Policy (CPCP).		
4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		12/01/2000
		Policy (CPCP).		
4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1.2,0 1.200
		Policy (CPCP).		
24162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, , , , , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4168	Amnioband, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2021	12/31/2999
	, 3	Submit for Recommended Clinical Review to avoid post-service review.		
(4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	-73, p q	review. Check EIU policy, which is one of our Clinical Payment and Coding		1-7-11-11-11
		Policy (CPCP).		
(4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	-73, p q	review. Check EIU policy, which is one of our Clinical Payment and Coding		1.2.2.1.2.2.2
		Policy (CPCP).		
24171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	,, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
)4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4177	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4177	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4178	Floweramniopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4178	Floweramniopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	5/45/0004	40/04/0000
24179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24400	D 11	Policy (CPCP).	40/4/0000	40/04/0000
Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24400	Davida wan anyana aantinaatan	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	40/4/0000	12/31/2999
Q4180	Revita, per square centimeter		12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4181	Amnio wound, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
24101	Amino wound, per square certimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
X+101	Amino wound, per square certaineter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
24182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		,
		Policy (CPCP).		
24182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	, , , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4183	Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4183	Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
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	12/1/2020	12/31/2999
	, , , , , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
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	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4186	Epifix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
(4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4193	Coll-e-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4193	Coll-e-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4194	Novachor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4194	Novachor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4197	Puraply xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4197	Puraply xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4198	Genesis amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4198	Genesis amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4199	Cygnus matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24400		Policy (CPCP).	4/45/0000	40/04/0000
Q4199	Cygnus matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24000	Objects and a second se	Policy (CPCP).	E/4E/0004	40/04/0000
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24200	Okin to management and the stan	Policy (CPCP).	E/4E/2024	40/04/0000
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24204	Matrices and any and another state	Policy (CPCP).	40/4/0000	40/04/0000
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24005		Policy (CPCP).	40/4/0000	10/04/0000
Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24205	Manakana anaftan manakana mana mana anatimatan	Policy (CPCP).	40/4/0000	40/04/0000
Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4206	Fluid flow or fluid GF, 1 cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
J4200	Fluid flow of fluid GF, 1 CC	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
X-200	Trada now of haid of , 1 cc	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
Z 0 0	Trans, per equal e commeter.	review. Check EIU policy, which is one of our Clinical Payment and Coding	, .,	12/01/2000
		Policy (CPCP).		
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4209	Surgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4209	Surgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	6/30/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4210	Axolotl graft or axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	6/30/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4212	Allogen, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4212	Allogen, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4213	Ascent, 0.5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.40.40	10.5	Policy (CPCP).	40/4/0000	10/04/0000
Q4213	Ascent, 0.5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24244	Callanta and management and invator	Policy (CPCP).	40/4/0000	12/31/2999
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
34214	Cellesia colu, per square ceritimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
Q 12 10	rivoleti diffizioni di dicioti di yo, c. i ing	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4216	Artacent cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4216	Artacent cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	Woundfix Xplus or BioWound Xplus, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
=		Policy (CPCP).	1011100	10/04/2222
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	Woundfix Xplus or BioWound Xplus, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
24040		Policy (CPCP).	10/1/0000	10/04/2000
Q4218	Surgicord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4218	Surgicord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4219	Surgigraft-dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4219	Surgigraft-dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4221	Amniowrap2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4221	Amniowrap2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4222	Progenamatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4222	Progenamatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	5/15/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.100.1	11 1 11 5 1 40 1 1 1 1 1 1 1 1 1 1	Policy (CPCP).	0/4/0000	40/04/0000
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
04004	Liver on health factor 40 americation at the f40 m/ man anyone	Policy (CPCP).	0/4/0000	40/04/0000
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4225	Amniching or dermohing the ner equare continuous	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/1/2022	12/31/2999
Q4223	Amniobind or dermabind tl, per square centimeter	· ·	0/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4225	Amniobind or dermabind tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2022	12/31/2999
Q4220	Aminophia of dermaphia ti, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2022	12/31/2999
		Policy (CPCP).		
Q4226	MyOwn skin, includes harvesting and preparation procedures,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
Q4220	per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	10/1/2024	12/31/2999
	per square certaineter	Policy (CPCP).		
Q4226	MyOwn skin, includes harvesting and preparation procedures,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2024	12/31/2999
~ · 	per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	. 3/ 1/2027	12/01/2000
	por oquaro continuoro	Policy (CPCP).		
Q4226	MyOwn skin, includes harvesting and preparation procedures,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	9/30/2024
~	per square centimeter	Submit for Recommended Clinical Review to avoid post-service review.	., ,,,,,,,,,,	0,00,2024
Q4227	Amniocore, per square centimeter		12/1/2020	12/31/2999
A 1221	, annicosto, por oqualo continuoto	review. Check EIU policy, which is one of our Clinical Payment and Coding	12, 1/2020	12/01/2000
		Policy (CPCP).		

Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4230	Cogenex flowable amnion, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4230	Cogenex flowable amnion, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
1004		Policy (CPCP).	40/4/0000	40/04/0000
)4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
1000		Policy (CPCP).	40/4/0000	40/04/0000
14232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24000	0	Policy (CPCP).	40/4/0000	40/04/0000
Q4232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24233	Surfactor or nudyn, per 0.5 cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2020	12/31/2999
14233	Surfactor or fludyff, per 0.5 cc	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
24233	Surfactor or nudyn, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
4200	Surfactor of fludyff, per 0.5 cc	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
14234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
(1201	7.00 morato, por oquaro continuotor	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/ 1/2020	12/01/2000
		Policy (CPCP).		
14234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, p, q	review. Check EIU policy, which is one of our Clinical Payment and Coding		,
		Policy (CPCP).		
14235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
)4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, ,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4237	Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4237	Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4239	Amnio-maxx or amnio-maxx lite, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4239	Amnio-maxx or amnio-maxx lite, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24040		Policy (CPCP).	40/4/0000	40/04/0000
Q4240	Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24240	Companies for torrigal was only man 0.5 as	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	40/4/0000	40/04/0000
Q4240	Corecyte, for topical use only, per 0.5 cc		12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4241	Polycyte, for topical use only, per 0.5 cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
J424 I	Polycyte, for topical use only, per 0.5 cc	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/31/2999
		Policy (CPCP).		
Q4241	Polycyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
X7271	l diyoyto, for topical accounty, per 0.0 co	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	,	review. Check EIU policy, which is one of our Clinical Payment and Coding		1.2
		Policy (CPCP).		
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	3/31/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	3/31/2024
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	, i	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4247	Amniotext patch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4247	Amniotext patch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4248	Dermacyte amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4248	Dermacyte amniotic membrane allograft, per square centimeter		12/1/2020	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4249	Amniply, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4249	Amniply, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.4054	V	Policy (CPCP).	4/45/0000	40/04/0000
Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24254	Vim per equere centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/45/2022	12/31/2999
Q4251	Vim, per square centimeter		4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4252	Vendaje, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/45/2022	12/31/2999
J4202	veridaje, per square ceritimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	4/13/2022	12/31/2999
Q4252	Vendaje, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
QTZUZ	vondaje, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	7/10/2022	12/3/1/2888
		Policy (CPCP).		
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
X7200	Zoniui annilotto membrane, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	7/10/2022	12/3/1/2333
		Policy (CPCP).		
		Policy (GPGP).		

Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/15/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4254	Novafix dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4254	Novafix dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	3/1/2021	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	0///0000	40/04/0000
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24050	Contrary to the contrary continue to the	Policy (CPCP).	0/4/0000	40/04/0000
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	8/1/2022	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4259	Celera dual layer or celera dual membrane, per square	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2022	12/31/2999
24233	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	1/1/2023	12/31/2999
	Certainletei	Policy (CPCP).		
24259	Celera dual layer or celera dual membrane, per square	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
X-1200	centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172020	12/01/2000
	Continues	Policy (CPCP).		
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	g	review. Check EIU policy, which is one of our Clinical Payment and Coding		1.2,0 11.2000
		Policy (CPCP).		
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		,
		Policy (CPCP).		
Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
	Ŭ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4262	Dual layer impax membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4262	Dual layer impax membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4263	Surgraft tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4263	Surgraft tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
	N. a. a.	Policy (CPCP).	01110000	10/04/0000
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.4005	N c a c	Policy (CPCP).	0/4/0000	10/01/0000
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.4000	No obtine manufacture in an annual acception of an	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/0000	12/31/2999
Q4266	Neostim membrane, per square centimeter		9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4266	Neostim membrane, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/2022	12/31/2999
J4200	Neostini membrane, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	9/1/2023	12/31/2999
		Policy (CPCP).		
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
37201	recostini di, per square continucter	review. Check EIU policy, which is one of our Clinical Payment and Coding	3/1/2023	12/01/2000
		Policy (CPCP).		
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
Q 1201	Troccum ai, por equale continued	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/1/2020	12/01/2000
		Policy (CPCP).		
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
<u></u>	Jang. and it, por equality contained.	review. Check EIU policy, which is one of our Clinical Payment and Coding	0, 1, 2020	1.2,01,2000
		Policy (CPCP).		
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
	, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	10///0000	10/01/0000
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
2.4070		Policy (CPCP).	40/4/0000	40/04/0000
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24074	Consession and an annual continuation	Policy (CPCP).	40/4/0000	40/04/0000
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4274	Esano ac, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2022	12/31/2999
34214	Esano ac, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2023	12/31/2999
		Policy (CPCP).		
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
X7210	Esano ada, per square dentimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
2.2.0	Loano ada, por equare continueter	review. Check EIU policy, which is one of our Clinical Payment and Coding	12/1/2020	12/01/2000
		Policy (CPCP).		
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding	,	1
		Policy (CPCP).		
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
	,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		, , , , , , , , , , , , , , , , , , , ,
		Policy (CPCP).		
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	6/30/2024
	9, p	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	6/30/2024
	3 /1 1	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4279	Vendaje ac, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4282	Cygnus dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4282	Cygnus dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24283	Biovance tri-layer or biovance 3l, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/15/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4286	Nudyn sl or nudyn slw, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	404440000	40/04/0000
Q4286	Nudyn sl or nudyn slw, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	10/1/2023	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4287	Dermabind dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4287	Dermabind dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4287	Dermabind dl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
(4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
00	Zomazma on, por oquaro commission	review. Check EIU policy, which is one of our Clinical Payment and Coding	., .,	12/01/2000
		Policy (CPCP).		
4288	Dermabind ch, per square centimeter		3/15/2024	6/30/2024
4200	Bernabila on, per square continueter	Submit for Recommended Clinical Review to avoid post-service review.	0/10/2024	0/00/2024
4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
4209	Trevostileid i attitilotic battlet, per square certifileter	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 172024	12/31/2999
		Policy (CPCP).		
4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
4209	Trevostileiu + attitilotic battlet, per square certifiletei	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 172024	12/31/2999
4200	Revoshield + amniotic barrier, per square centimeter	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
4289	Revosnieid + amniotic barrier, per square centimeter		3/13/2024	0/30/2024
1000	Managharan and bandaran and an analysis of a	Submit for Recommended Clinical Review to avoid post-service review.	7/4/0004	40/04/0000
4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4290	Membrane wrap-hydro, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4291	Lamellas xt, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	, ,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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).		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).		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

Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4298	Amnicore pro, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4299	Amnicore pro+, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4300	Acesso tl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
24301	Activate matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4301	Activate matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4301	Activate matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24302	Complete aca, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
24303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4303	Complete aa, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	6/30/2024
		Submit for Recommended Clinical Review to avoid post-service review.		
04304	Grafix plus, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/15/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4306	American amnion ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4306	American amnion ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4307	American amnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4307	American amnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4308	Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24308	Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
1010		Policy (CPCP).	4/4/0004	10/01/0000
Q4310	Procenta, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
1210	Procenta, per 100 mg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	4/4/2024	12/31/2999
Q4310	Procenta, per 100 mg		4/ 1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
(4011	Acesso, per square certifficier	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 172024	12/31/2999
		Policy (CPCP).		
4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	7 to 5555, por oqual o continuotor	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 17202 1	12/01/2000
		Policy (CPCP).		
4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4313	Dermabind fm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4313	Dermabind fm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4314	Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
<u></u>	. toota 1, por oqualo osililinoto.	review. Check EIU policy, which is one of our Clinical Payment and Coding	., .,	12/01/2000
		Policy (CPCP).		
Q4314	Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.10.10		Policy (CPCP).	=///0004	10/01/0000
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
04047	Vita mafe man amount acception at an	Policy (CPCP).	7/4/2024	40/04/0000
Q4317	Vitograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4317	Vitograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
Q 1 011	Vitografit, per square certaineter	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172024	12/01/2000
		Policy (CPCP).		
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	_ g, p q	review. Check EIU policy, which is one of our Clinical Payment and Coding	., .,	1-2.7
		Policy (CPCP).		
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
0.1000		Policy (CPCP).	=///0004	10/01/0000
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4320	Pellograft, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
Q432U	reliografi, per square certimeter		77 172024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
Q4321	The nogran, per square certimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	111/2024	12/3/1/2999
		Policy (CPCP).		
		Iruilay (arar).		

Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4324	Amniotx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).	=///000 /	10/04/0000
Q4324	Amniotx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
24005	A t-t-t	Policy (CPCP).	7/4/0004	40/04/0000
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
04225	A soundale management continuation	Policy (CPCP).	7/4/0004	40/04/0000
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
Q4326	Woundplus, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
J4320	Woundplus, per square centimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	11112024	12/31/2999
		Policy (CPCP).		
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
Q-1020	vvoundplas, per square sentimeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	17 172024	12/01/2000
		Policy (CPCP).		
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1.20.1.200
		Policy (CPCP).		
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4328	Most, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4328	Most, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	omgray, per equate continuetor	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 17202 1	12/01/2000
		Policy (CPCP).		
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
21000	Total, por oqualo continuctor	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 17202 1	12/01/2000
		Policy (CPCP).		
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
x 1000	Total, por oqualo continuctor	review. Check EIU policy, which is one of our Clinical Payment and Coding	77 17202 1	12/01/2000
		Policy (CPCP).		
24331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	, storest grant, per equal e consumeter	review. Check EIU policy, which is one of our Clinical Payment and Coding	.,.,	. = / 0 . / = 000
		Policy (CPCP).		
4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	, who said grant, por square somethings	review. Check EIU policy, which is one of our Clinical Payment and Coding	.,.,	12/01/2000
		Policy (CPCP).		
24332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	,gg, p	review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
	, troisis addignary, per equal e commission	review. Check EIU policy, which is one of our Clinical Payment and Coding	.,.,	12/01/2000
		Policy (CPCP).		
4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
.000	, acceptant, per equal e contamente.	review. Check EIU policy, which is one of our Clinical Payment and Coding	.,.,	12/01/2000
		Policy (CPCP).		
4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7/1/2024	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		1.2,0 11.200
		Policy (CPCP).		
5106	Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/15/2020	12/31/2999
	use), 1000 units	Submit for Recommended Clinical Review to avoid post-service review.		
5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/1/2020	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2022	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5128	Injection, ranibizumab-egrn (cimerli), biosimilar, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	6/1/2023	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	8/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/1/2024	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	7/15/2024	12/31/2999
	1 mg	Submit for Recommended Clinical Review to avoid post-service review.		
0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	2/1/2021	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
0117	Tretinoin, topical, 5 grams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
0142	COLISTIMETHATE SODIUM, INHALATION SOLUTION		4/1/2005	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM,	service review.		
	PER MG			
0155	Sterile dilutant for epoprostenol, 50ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		

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
00400	T		E/4E/0040	0/4 4/0004
80189	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 preservice review.	4/1/2005	12/31/2999
S0207	Paramedic intercept, non-hospital-based als service (non-	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
20000	voluntary), non-transport	service review.	4/4/0004	40/04/0000
80209	Wheelchair van, mileage, per mile	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999
30215	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		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 preservice review.	11/1/2011	12/31/2999
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
S2080	Laser-assisted uvulopalatoplasty (laup)	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	9/1/2020	12/31/2999
S2102	Islet cell tissue transplant from pancreas; allogeneic	Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/15/2023	12/31/2999
S2103	Adrenal tissue transplant to brain	Submit for Recommended Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	11/1/2019	12/31/2999
S2112	Arthroscopy, knee, surgical for harvesting of cartilage		5/1/2022	12/31/2999
S2117	(chondrocyte cells) Arthroereisis, subtalar	Submit for Recommended Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject 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		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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
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		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
52409	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	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 preservice review.		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 preservice 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
53652	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 preservice review.	1/1/1950	12/31/2999

S4027	Storage of previously frozen embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
S4030	Sperm procurement and cryopreservation services; initial visit	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
0.000	Sporting productions and dryoprodorvation convictor, initial viole	service review.	17 17 1000	12/01/2000
S4031	Sperm procurement and cryopreservation services; subsequent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	visit	service review.	., ., .,	12/01/2000
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5101	Day care services, adult; per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
05400		service review.	4/4/4050	10/04/0000
S5102	Day care services, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
25405	Decree and the control of the contro	service review.	4/4/4050	40/04/0000
S5105	Day care services, center-based; services not included in	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
S5108	program fee, per diem	Service review.	1/1/1050	12/31/2999
55108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
S5109	Home care training to home care client, per session	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
55109	nome care training to nome care client, per session	service review.	1/1/1950	12/31/2999
S5110	Home care training, family; per 15 minutes		1/1/1950	12/31/2999
00110	Tiome care training, family, per 15 minutes	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-	1/1/1950	12/31/2999
00111	Trome care training, family, per session	Iservice review.	17 17 1330	12/01/2000
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
00110	Tromo dalo traning, non family, por 10 minutos	service review.	17 17 1000	12/01/2000
S5116	Home care training, non-family; per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	γ, γ	service review.		12.2
S5120	Chore services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5121	Chore services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5135	Companion care, adult (e. G. ladl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5136	Companion care, adult (e. G. ladl/adl); per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		

S5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
05444	Footon constable constable	service review.	4/4/4050	40/04/0000
S5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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-	1/1/1950	12/31/2999
00110	Toolor sais, incrapsais, orma, per alom	service review.	17 17 1000	12/01/2000
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
0=100		service review.	4/4/4050	10/01/0000
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
S5161	Emergency response system; service fee, per month (excludes	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
33101	installation and testing)	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-	1/1/1950	12/31/2999
00102	Emergency response system, purchase only	Iservice review.	1/ 1/ 1330	12/01/2000
S5165	Home modifications; per service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
20.00	. 15.113 . 11	service review.	., ., .,	12/01/2000
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	, 31 1 /1	service review.		
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S5199	Personal care item, nos, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	4/1/2009	12/31/2999
00010		Submit for Recommended Clinical Review to avoid post-service review.	0///000/	10/01/0000
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	3/1/2024	12/31/2999
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	Submit for Recommended Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	0/4/2020	12/31/2999
30130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	review. Check EIU policy, which is one of our Clinical Payment and Coding	9/1/2020	12/31/2999
		Policy (CPCP).		
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	9/1/2020	12/31/2999
00100	THE EXERTIME CONTROL OF THE CONTROL	review. Check EIU policy, which is one of our Clinical Payment and Coding	0/ 1/2020	12/01/2000
		Policy (CPCP).		
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	11/1/2016	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	11/1/2016	12/31/2999
		review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	7/1/2005	12/31/2999
		service review.		121212
S8415	Supplies for home delivery of infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
00400	Ownite the most sector to the most	service review.	4/4/4050	40/04/0000
S8460	Camisole, post-mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		

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

S9447	Infant safety (including cpr) classes, non-physician provider, per	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
	session	service review.		
S9449	Weight management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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		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 preservice 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 preservice 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		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 preservice 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 preservice 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 preservice 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 preservice 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))	service review.	1/1/1950	12/31/2999
S9990	Services provided as part of a phase ii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	1/1/1950	12/31/2999
S9991	Services provided as part of a phase iii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	1/1/1950	12/31/2999

S9992	Transportation costs to and from trial location and local	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	transportation costs (e. G., fares for taxicab or bus) for clinical	service review.		
	trial participant and one caregiver/companion			
89994	Lodging costs (e. G., hotel charges) for clinical trial participant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	and one caregiver/companion	service review.		
S9996	Meals for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
S9999	Sales tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
/2025	Deluxe frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
		service review.		
/2219	Bifocal seg width over 28mm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
/2600	Hand held low vision aids and other nonspectacle mounted aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	'	service review.		
V2610	Single lens spectacle mounted low vision aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
	g	service review.		12.2.1.2.2.2
V2615	Telescopic and other compound lens system, including distance		1/1/1950	12/31/2999
0 . 0	vision telescopic, near vision telescopes and compound	service review.	., ., .,	12/01/2000
	microscopic lens system	SOLVIOU TOVIOW.		
/2627	Scleral cover shell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	5/15/2016	12/31/2999
2021	Coloral coval cricii	Submit for Recommended Clinical Review to avoid post-service review.	0/ 10/2010	12/01/2000
/2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
2102	DELOXE LENOT EXTORE	service review.	1/1/2021	12/01/2000
/2715	Prism, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
727 13	i fishi, per lens	service review.	1/1/1930	12/31/2999
/2718	Press-on lens, fresnell prism, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
727 10	i ress-off leffs, freshell prisht, per leffs	service review.	1/1/1930	12/31/2999
/2730	Special base curve, glass or plastic, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1050	12/31/2999
12130	Special base culve, glass of plastic, per letis	service review.	1/1/1930	12/3/1/2999
/2744	Tint, photochromatic, per lens		1/1/1950	12/31/2999
12144	Tilli, priotociliomatic, per lens	service review.	1/1/1930	12/31/2999
/2750	Anti-reflective coating, per lens		1/1/1950	12/31/2999
12130	Anti-reflective coating, per feris	· · · · · · · · · · · · · · · · · · ·	1/1/1930	12/31/2999
/2755	U-v lens, per lens	service review.	4/4/4050	12/31/2999
/2/55	U-v iens, per iens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
/2760	0	service review.	4/4/4050	40/04/0000
/2/60	Scratch resistant coating, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
10770		service review.	4/4/4050	10/01/0000
/2770	Occluder lens, per lens	, , ,	1/1/1950	12/31/2999
·	A OTTOMATION ASSESSMENT OF INTERACTION OF INTERACTION OF	service review.	10/15/0000	10/01/0000
/2787		MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2008	12/31/2999
10700	LENS	Submit for Recommended Clinical Review to avoid post-service review.	40/45/0000	10/01/0000
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	10/15/2008	12/31/2999
	LENS	Submit for Recommended Clinical Review to avoid post-service review.		
V2799	Vision item or service, miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
√5095	Semi-implantable middle ear hearing prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria.	1/1/1950	12/31/2999
		Submit for Recommended Clinical Review to avoid post-service review.		
/5364	Dysphagia screening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		

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