

2025 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List - Fully Insured Effective 1/1/2025 through 1/1/2026 (Updated December 2025)

Our medical policy impacts all our coverage decisions. This list includes Curre Common Procedure Coding System codes that, based on our medical policy, a - 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) Except as otherwise noted in the date column, these codes are effective on or	are: ' benefit plans) ' 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 Gro	up Description		
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against <u>Medical</u> <u>Clinical Review</u> to avoid post-service review.	Policy criteria. Submit for <u>Recommended</u>		
	Highlighted procedure/service in this code group contract agreement.	p may require Prior Authorization per		
Rotary Wing & Ground Ambulance	MP Criteria: Procedure/service reviewed agains Recommended Clinical Review to avoid post-se			
Non Covered	Procedures/services not covered by the Plan.	Not subject to pre-service review.		
Experimental, Investigational, Unproven		Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our <u>Clinical Payment and Coding Policies.</u>		
Unlisted or Undefined	Procedures/services not specifically defined or o contract/clinical review.	classified, may be subject to		
Note: Some codes will appear twice if Ending	Date and Effective Date are within the same quarter perio	hd		

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

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

15274	Application of skin substitute graft to trunk, arms, legs, total wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	surface area greater than or equal to 100 sq cm; each additional 100 sq	Medical Policy Criteria. Submit for Recommended		
	cm wound surface area, or part thereof, or each additional 1% of body	Clinical Review to avoid post-service review.		
	area of infants and children, or part thereof (List separately in addition to			
	code for primary procedure)			
5275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Clinical Review to avoid post-service review.		
5276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area up to 100 sq cm; each additional 25 sq cm wound surface	Clinical Review to avoid post-service review.		
	area, or part thereof (List separately in addition to code for primary			
	procedure)			
5277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area greater than or equal to 100 sq cm; first 100 sq cm wound	Clinical Review to avoid post-service review.		
	surface area, or 1% of body area of infants and children			
5278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area greater than or equal to 100 sq cm; each additional 100 sq	Clinical Review to avoid post-service review.		
	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	11/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	fat, dermis, fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5771	Grafting of autologous fat harvested by liposuction technique to trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	breasts, scalp, arms, and/or legs; 50 cc or less injectate	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5772	Grafting of autologous fat harvested by liposuction technique to trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part	Medical Policy Criteria. Submit for Recommended		
	thereof (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
5775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. 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	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids,	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	general keratosis)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

15783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15787	Abrasion; each additional 4 lesions or less (List separately in addition to	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15819	Cervicoplasty	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
15820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15824	Rhytidectomy; forehead	MP Criteria: Procedure/service reviewed against	9/24/2012	9/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15826	Rhytidectomy; glabellar frown lines	MP Criteria: Procedure/service reviewed against	9/24/2012	9/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	abdomen, infraumbilical panniculectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10002	thigh	Medical Policy Criteria. Submit for Recommended	0/2 1/2012	12/01/2000
		Clinical Review to avoid post-service review.		
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10000	leg	Medical Policy Criteria. Submit for Recommended	0/24/2012	12/01/2000
	icy	Clinical Review to avoid post-service review.		
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10004	hip	Medical Policy Criteria. Submit for Recommended	5/24/2012	12/01/2000
	Tilp	Clinical Review to avoid post-service review.		
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10000	buttock	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
	DULLOCK	,		
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10000		5	9/24/2012	12/31/2999
	arm	Medical Policy Criteria. Submit for Recommended		
45007		Clinical Review to avoid post-service review.	0/04/0010	42/24/2000
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	forearm or hand	Medical Policy Criteria. Submit for Recommended		
15000		Clinical Review to avoid post-service review.	0/04/0040	40/04/0000
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	submental fat pad	Medical Policy Criteria. Submit for Recommended		
15000		Clinical Review to avoid post-service review.	0/0//00/0	
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	other area	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy),	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	abdomen (eg, abdominoplasty) (includes umbilical transposition and	Medical Policy Criteria. Submit for Recommended		
	fascial plication) (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
15876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15879	Suction assisted lipectomy; lower extremity	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	technique); less than 10 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	technique); 10.0 to 50.0 sq cm	Medical Policy Criteria. Submit for Recommended	// // 1000	12/01/2000
		Clinical Review to avoid post-service review.		
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17108	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	technique); over 50.0 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
17340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
17360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	each fibroadenoma	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19300	Mastectomy for gynecomastia	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	, , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19316	Mastopexy	MP Criteria: Procedure/service reviewed against	1/1/1950	4/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19318	Breast reduction	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19330	Removal of ruptured breast implant, including implant contents (eg,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	saline, silicone gel)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19342	Insertion or replacement of breast implant on separate day from	MP Criteria: Procedure/service reviewed against	7/1/2005	12/31/2999
	mastectomy	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
19350	Nipple/areola reconstruction	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

19355	Correction of inverted nipples	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
19357	Tissue expander placement in breast reconstruction, including	MP Criteria: Procedure/service reviewed against	6/1/2017		12/31/2999
	subsequent expansion(s)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
19370	Revision of peri-implant capsule, breast, including capsulotomy,	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
	capsulorrhaphy, and/or partial capsulectomy	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
19371	Peri-implant capsulectomy, breast, complete, including removal of all	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
	intracapsular contents	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
19499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against	11/1/2017		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's	MP Criteria: Procedure/service reviewed against	1/1/2012		12/31/2999
	contracture)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
20561	Needle insertion(s) without injection(s); 3 or more muscles	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	······································	Not subject to pre-service review. Check EIU policy,			,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
20561	Needle insertion(s) without injection(s); 3 or more muscles	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
	(nonoperative)	Medical Policy Criteria. Submit for Recommended			
	(Clinical Review to avoid post-service review.			
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors	MP Criteria: Procedure/service reviewed against	8/15/2007		12/31/2999
	(eg, metastasis) including adjacent soft tissue when involved by tumor	Medical Policy Criteria. Submit for Recommended			
	extension, percutaneous, including imaging guidance when performed;	Clinical Review to avoid post-service review.			
	radiofrequency				
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors	MP Criteria: Procedure/service reviewed against	1/1/2020		12/31/2999
	(eg, metastasis) including adjacent soft tissue when involved by tumor	Medical Policy Criteria. Submit for Recommended			, 0 //2000
	extension, percutaneous, including imaging guidance when performed;	Clinical Review to avoid post-service review.			
	cryoablation				
20985	Computer-assisted surgical navigational procedure for musculoskeletal	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
20000	procedures, image-less (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,		5/1/2020	12/51/2999
	procedures, image-less (List separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
	procedure)	which is one of our chinical Payment and Coulling			

20985	Computer-assisted surgical navigational procedure for musculoskeletal	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	procedures, image-less (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,		
	procedure)	which is one of our Clinical Payment and Coding		
21032	Excision of maxillary torus palatinus	Policy (CPCP). Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
21032	Excision of maximary torus paratinus	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
210/5	an anesthesia service (ie, general or monitored anesthesia care)	Medical Policy Criteria. Submit for Recommended	1/10/2010	12/31/2999
		Clinical Review to avoid post-service review.		
21083	Impression and custom preparation; palatal lift prosthesis	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21121	Genioplasty; sliding osteotomy, single piece	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	excision or bone wedge reversal for asymmetrical chin)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21123	Genioplasty; sliding, augmentation with interpositional bone grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	(includes obtaining autografts)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	mandibular staple bone plate)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
04040	December of more like an example and marked involute to the	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade,	Clinical Review to avoid post-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
21240			1/1/1950	12/31/2999
21249	cylinder); partial Reconstruction of mandible or maxilla, endosteal implant (eg, blade,	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
21249	cylinder); complete	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
21005		Medical Policy Criteria. Submit for Recommended	5/15/2024	12/31/2999
		Clinical Review to avoid post-service review.		
22505	Manipulation of spine requiring anesthesia, any region	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,01,2000
		Clinical Review to avoid post-service review.		
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	bilateral including fluoroscopic guidance; single level	Not subject to pre-service review. Check EIU policy,	1/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	bilateral including fluoroscopic guidance; single level	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	bilateral including fluoroscopic guidance; 1 or more additional levels (List	Not subject to pre-service review. Check EIU policy,			
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	bilateral including fluoroscopic guidance; 1 or more additional levels (List	Not subject to pre-service review. Check EIU policy,			
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22586	Arthrodesis, pre-sacral interbody technique, including disc space	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	preparation, discectomy, with posterior instrumentation, with image	Not subject to pre-service review. Check EIU policy,			
	guidance, includes bone graft when performed, L5-S1 interspace	which is one of our Clinical Payment and Coding			
00500		Policy (CPCP).	0.11/00.00		10/01/0000
22586	Arthrodesis, pre-sacral interbody technique, including disc space	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	preparation, discectomy, with posterior instrumentation, with image	Not subject to pre-service review. Check EIU policy,			
	guidance, includes bone graft when performed, L5-S1 interspace	which is one of our Clinical Payment and Coding			
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
22030	performed; up to 7 vertebral segments	Not subject to pre-service review. Check EIU policy,		5/15/2024	12/31/2999
	performed, up to 7 vertebral segments	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
22030	performed; up to 7 vertebral segments	Not subject to pre-service review. Check EIU policy,	5/15/2024		12/31/2333
	performed, up to 7 vertebrar segments	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	performed; up to 7 vertebral segments	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	performed; 8 or more vertebral segments	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	performed; 8 or more vertebral segments	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	performed; 8 or more vertebral segments	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
22838	Revision (eg, augmentation, division of tether), replacement, or removal	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	of thoracic vertebral body tethering, including thoracoscopy, when	Not subject to pre-service review. Check EIU policy,			
	performed	which is one of our Clinical Payment and Coding			
00000		Policy (CPCP).	E/4 E /2000		10/01/0000
22838	Revision (eg, augmentation, division of tether), replacement, or removal	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	of thoracic vertebral body tethering, including thoracoscopy, when	Not subject to pre-service review. Check EIU policy,			
	performed	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

22838	Revision (eg, augmentation, division of tether), replacement, or removal	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	of thoracic vertebral body tethering, including thoracoscopy, when	Medical Policy Criteria. Submit for Recommended			
	performed	Clinical Review to avoid post-service review.			
22867	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	device, without fusion, including image guidance when performed, with	Not subject to pre-service review. Check EIU policy,			
	open decompression, lumbar; single level	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22867	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	device, without fusion, including image guidance when performed, with	Not subject to pre-service review. Check EIU policy,			
	open decompression, lumbar; single level	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
22868	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	device, without fusion, including image guidance when performed, with	Not subject to pre-service review. Check EIU policy,			
	open decompression, lumbar; second level (List separately in addition to	which is one of our Clinical Payment and Coding			
	code for primary procedure)	Policy (CPCP).			
22868	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	device, without fusion, including image guidance when performed, with	Not subject to pre-service review. Check EIU policy,			
	open decompression, lumbar; second level (List separately in addition to	which is one of our Clinical Payment and Coding			
	code for primary procedure)	Policy (CPCP).			
22869	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	device, without open decompression or fusion, including image guidance	Not subject to pre-service review. Check EIU policy,			
	when performed, lumbar; single level	which is one of our Clinical Payment and Coding			
00000		Policy (CPCP).	4/4/0000		40/04/0000
22869	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	device, without open decompression or fusion, including image guidance	Not subject to pre-service review. Check EIU policy,			
	when performed, lumbar; single level	which is one of our Clinical Payment and Coding			
22870	Insertion of interlaminar/interspinous process stabilization/distraction	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
22010				1/1/2023	12/31/2999
	device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
	for primary procedure)	Policy (CPCP).			
22870	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
22070	device, without open decompression or fusion, including image guidance	Not subject to pre-service review. Check EIU policy,	1/ 1/2025		12/31/2999
	when performed, lumbar; second level (List separately in addition to code				
	for primary procedure)	Policy (CPCP).			
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed against	11/1/2017		12/31/2999
20020		Medical Policy Criteria. Submit for Recommended	11/1/2017		12/01/2000
		Clinical Review to avoid post-service review.			
24300	Manipulation, elbow, under anesthesia	MP Criteria: Procedure/service reviewed against	1/15/2013		12/31/2999
		Medical Policy Criteria. Submit for Recommended			,
		Clinical Review to avoid post-service review.			
25259	Manipulation, wrist, under anesthesia	MP Criteria: Procedure/service reviewed against	1/15/2013		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
26340	Manipulation, finger joint, under anesthesia, each joint	MP Criteria: Procedure/service reviewed against	1/15/2013		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
26341	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme	MP Criteria: Procedure/service reviewed against	1/1/2012		12/31/2999
	injection (eg, collagenase), single cord	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

27275	Manipulation, hip joint, requiring general anesthesia	MP Criteria: Procedure/service reviewed against	6/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including		5/15/2024	12/31/2999
	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic	Not subject to pre-service review. Check EIU policy,		
	device[s]), without placement of transfixation device	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including		5/15/2024	12/31/2999
	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic	Not subject to pre-service review. Check EIU policy,		
	device[s]), without placement of transfixation device	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
-	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic	Medical Policy Criteria. Submit for Recommended		
	device[s]), without placement of transfixation device	Clinical Review to avoid post-service review.		
27299	Unlisted procedure, pelvis or hip joint	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27702	Arthroplasty, ankle; with implant (total ankle)	MP Criteria: Procedure/service reviewed against	12/15/2009	12/31/2999
21102		Medical Policy Criteria. Submit for Recommended	12/10/2000	12/01/2000
		Clinical Review to avoid post-service review.		
27703	Arthroplasty, ankle; revision, total ankle	MP Criteria: Procedure/service reviewed against	5/1/2015	12/31/2999
21100		Medical Policy Criteria. Submit for Recommended	0/1/2010	12/01/2000
		Clinical Review to avoid post-service review.		
27860	Manipulation of ankle under general anesthesia (includes application of	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
27000	traction or other fixation apparatus)	Medical Policy Criteria. Submit for Recommended	1/10/2010	12/31/2999
	liaction of other fixation apparatus	Clinical Review to avoid post-service review.		
28890	Extracorporeal shock wave, high energy, performed by a physician or	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
20090	other qualified health care professional, requiring anesthesia other than	Not subject to pre-service review. Check EIU policy,	9/ 1/2020	12/31/2999
	local, including ultrasound guidance, involving the plantar fascia	which is one of our Clinical Payment and Coding		
	local, including ultrasound guidance, involving the plantar fascia	Policy (CPCP).		
28890	Extracorporeal shock wave, high energy, performed by a physician or	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	other qualified health care professional, requiring anesthesia other than	Not subject to pre-service review. Check EIU policy,		
	local, including ultrasound guidance, involving the plantar fascia	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(chondroplasty), abrasion arthroplasty, and/or resection of labrum	Medical Policy Criteria. Submit for Recommended	., .,	
		Clinical Review to avoid post-service review.		
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty)		1/1/2005	12/31/2999
20000	(includes harvesting of the autograft[s])	Medical Policy Criteria. Submit for Recommended	., .,	
		Clinical Review to avoid post-service review.		
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
20001		Medical Policy Criteria. Submit for Recommended	0/10/2001	12/01/2000
		Clinical Review to avoid post-service review.		
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy		1/1/2022	12/31/2999
20000	for meniscal insertion), medial or lateral	Medical Policy Criteria. Submit for Recommended	1, 1, 2022	12,0172000
		Clinical Review to avoid post-service review.		
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
23314		Medical Policy Criteria. Submit for Recommended	1/ 1/2011	12/31/2333
		Clinical Review to avoid post-service review.		

29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer	MP Criteria: Procedure/service reviewed against	1/1/2011		12/31/2999
	lesion)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
29916	Arthroscopy, hip, surgical; with labral repair	MP Criteria: Procedure/service reviewed against	1/1/2011		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against	11/1/2017		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
	implant(s)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall		5/15/2021		12/31/2999
	implant(s)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie,	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	radiofrequency) subcutaneous/submucosal remodeling	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie,		1/1/2023		12/31/2999
	radiofrequency) subcutaneous/submucosal remodeling	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	ablation, posterior nasal nerve	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	ablation, posterior nasal nerve	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	ablation, posterior nasal nerve	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation,	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	posterior nasal nerve	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	posterior nasal nerve	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation,	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	posterior nasal nerve	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	11/1/2019		12/31/2999
	performed; with balloon occlusion, when performed, assessment of air	Medical Policy Criteria. Submit for Recommended			
	leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Clinical Review to avoid post-service review.			

31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33213	Insertion of pacemaker pulse generator only; with existing dual leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against	4/15/2006	12/31/2999
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999

33276	Insertion of phrenic nerve stimulator system (pulse generator and	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	stimulating lead[s]), including vessel catheterization, all imaging guidance,				
	and pulse generator initial analysis with diagnostic mode activation, when	which is one of our Clinical Payment and Coding			
	performed	Policy (CPCP).			
33276	Insertion of phrenic nerve stimulator system (pulse generator and	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	stimulating lead[s]), including vessel catheterization, all imaging guidance,				
	and pulse generator initial analysis with diagnostic mode activation, when	which is one of our Clinical Payment and Coding			
	performed	Policy (CPCP).			
33276	Insertion of phrenic nerve stimulator system (pulse generator and	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
l	stimulating lead[s]), including vessel catheterization, all imaging guidance,				
	and pulse generator initial analysis with diagnostic mode activation, when	Clinical Review to avoid post-service review.			
	performed				
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
00077		Policy (CPCP).	E/15/000 f		10/01/0000
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
33277	Inaction of phranic parks stimulator transvensus consing load (List	Policy (CPCP). MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
33211	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended	2/15/2024		3/14/2024
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.			
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
00210	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,		5/15/2024	12/01/2000
	system, including pulse generator and lead(s)	which is one of our Clinical Payment and Coding			
	system, molitaing pulse generator and read(s)	Policy (CPCP).			
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,			
	system, including pulse generator and lead(s)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	imaging guidance, and interrogation and programming, when performed;	Medical Policy Criteria. Submit for Recommended			
	system, including pulse generator and lead(s)	Clinical Review to avoid post-service review.			
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,			
	transvenous stimulation or sensing lead(s) only	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			10/01/0005
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,			
	transvenous stimulation or sensing lead(s) only	which is one of our Clinical Payment and Coding			
22270	Demoval of abrania name atimulator, including vacant activation all	Policy (CPCP). MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all	•	2/15/2024		5/14/2024
	imaging guidance, and interrogation and programming, when performed;	Medical Policy Criteria. Submit for Recommended	1		
33280	transvenous stimulation or sensing lead(s) only Removal of phrenic nerve stimulator, including vessel catheterization, all	Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
55200		•		5/15/2024	12/31/2999
	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,			
	pulse generator only	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

33280	Removal of phrenic nerve stimulator, including vessel catheterization, all	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
55200	imaging guidance, and interrogation and programming, when performed;	Not subject to pre-service review. Check EIU policy,	5/15/2024		12/31/2333
	pulse generator only	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	imaging guidance, and interrogation and programming, when performed;	Medical Policy Criteria. Submit for Recommended			
	pulse generator only	Clinical Review to avoid post-service review.			
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	MP Criteria: Procedure/service reviewed against	1/1/2019		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
33287	Removal and replacement of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and programming,	Not subject to pre-service review. Check EIU policy,			
	when performed; pulse generator	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33287	Removal and replacement of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	catheterization, all imaging guidance, and interrogation and programming,	Not subject to pre-service review. Check EIU policy,			
	when performed; pulse generator	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33287	Removal and replacement of phrenic nerve stimulator, including vessel	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	catheterization, all imaging guidance, and interrogation and programming,	Medical Policy Criteria. Submit for Recommended			
	when performed; pulse generator	Clinical Review to avoid post-service review.			
33288	Removal and replacement of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	when performed; transvenous stimulation or sensing lead(s)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33288	Removal and replacement of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	when performed; transvenous stimulation or sensing lead(s)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
33288	Removal and replacement of phrenic nerve stimulator, including vessel	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	catheterization, all imaging guidance, and interrogation and programming,	Medical Policy Criteria. Submit for Recommended			
	when performed; transvenous stimulation or sensing lead(s)	Clinical Review to avoid post-service review.			
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor	MP Criteria: Procedure/service reviewed against	1/1/2019		12/31/2999
	for long-term hemodynamic monitoring, including deployment and	Medical Policy Criteria. Submit for Recommended			
	calibration of the sensor, right heart catheterization, selective pulmonary	Clinical Review to avoid post-service review.			
	catheterization, radiological supervision and interpretation, and pulmonary				
	artery angiography, when performed		1		

33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; percutaneous femoral artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; open femoral artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; open axillary artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; open iliac artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	valve; transapical exposure (eg, left thoracotomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; cardiopulmonary bypass support with percutaneous peripheral	Medical Policy Criteria. Submit for Recommended		
	arterial and venous cannulation (eg, femoral vessels) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)			
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; cardiopulmonary bypass support with open peripheral arterial and	Medical Policy Criteria. Submit for Recommended		
	venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)			
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; cardiopulmonary bypass support with central arterial and venous	Medical Policy Criteria. Submit for Recommended		
	cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)			
33418	Transcatheter mitral valve repair, percutaneous approach, including	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
	transseptal puncture when performed; initial prosthesis	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33419	Transcatheter mitral valve repair, percutaneous approach, including	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
	transseptal puncture when performed; additional prosthesis(es) during	Medical Policy Criteria. Submit for Recommended		
	same session (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
33477	Transcatheter pulmonary valve implantation, percutaneous approach,	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	including pre-stenting of the valve delivery site, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33927	Implantation of a total replacement heart system (artificial heart) with	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	recipient cardiectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33928	Removal and replacement of total replacement heart system (artificial	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	heart)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

36465	Injection of non-compounded foam sclerosant with ultrasound	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
00400	compression maneuvers to guide dispersion of the injectate, inclusive of	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/01/2000
	all imaging guidance and monitoring; single incompetent extremity truncal	Clinical Review to avoid post-service review.		
	vein (eg, great saphenous vein, accessory saphenous vein)			
36466	Injection of non-compounded foam sclerosant with ultrasound	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	compression maneuvers to guide dispersion of the injectate, inclusive of	Medical Policy Criteria. Submit for Recommended		
	all imaging guidance and monitoring; multiple incompetent truncal veins	Clinical Review to avoid post-service review.		
	(eg, great saphenous vein, accessory saphenous vein), same leg			
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/2 //20 /2	12/01/2000
		Clinical Review to avoid post-service review.		
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
36471	Injection of sclerosant; multiple incompetent veins (other than	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00111	telangiectasia), same leg	Medical Policy Criteria. Submit for Recommended	1, 1, 1000	12/01/2000
	tolangiootabla), barno log	Clinical Review to avoid post-service review.		
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020) 12/31/2999
00410	all imaging guidance and monitoring, percutaneous, mechanochemical;	Not subject to pre-service review. Check EIU policy,	12, 1/2020	12/01/2000
	first vein treated	which is one of our Clinical Payment and Coding		
	inst vent treated	Policy (CPCP).		
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
00470	all imaging guidance and monitoring, percutaneous, mechanochemical;	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
	first vein treated	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020) 12/31/2999
00111	all imaging guidance and monitoring, percutaneous, mechanochemical;	Not subject to pre-service review. Check EIU policy,	12, 1/2020	12/01/2000
	subsequent vein(s) treated in a single extremity, each through separate	which is one of our Clinical Payment and Coding		
	access sites (List separately in addition to code for primary procedure)	Policy (CPCP).		
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	all imaging guidance and monitoring, percutaneous, mechanochemical;	Not subject to pre-service review. Check EIU policy,	, .,	12/01/2000
	subsequent vein(s) treated in a single extremity, each through separate	which is one of our Clinical Payment and Coding		
	access sites (List separately in addition to code for primary procedure)	Policy (CPCP).		
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, radiofrequency; first	Medical Policy Criteria. Submit for Recommended		
	vein treated	Clinical Review to avoid post-service review.		
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, radiofrequency;	Medical Policy Criteria. Submit for Recommended	0, 1,2000	12/01/2000
	subsequent vein(s) treated in a single extremity, each through separate	Clinical Review to avoid post-service review.		
	access sites (List separately in addition to code for primary procedure)			
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, laser; first vein	Medical Policy Criteria. Submit for Recommended		
	treated	Clinical Review to avoid post-service review.		
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
00-10	all imaging guidance and monitoring, percutaneous, laser; subsequent	Medical Policy Criteria. Submit for Recommended	0, 1,2000	12/01/2000
	vein(s) treated in a single extremity, each through separate access sites	Clinical Review to avoid post-service review.		
	(List separately in addition to code for primary procedure)	Cirrical Neview to avoid post-service review.		
	ILEISE Separately in addition to code for primary procedure)		1	1

36482	Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against	9/1/2019	12/31/2999
50402	transcatheter delivery of a chemical adhesive (eq. cyanoacrylate) remote	Medical Policy Criteria. Submit for Recommended	5/ 1/2015	12/31/2333
	from the access site, inclusive of all imaging guidance and monitoring,	Clinical Review to avoid post-service review.		
	percutaneous: first vein treated	Clinical Review to avoid post-service review.		
36483	Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against	9/1/2019	12/31/2999
00+00	transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote	Medical Policy Criteria. Submit for Recommended	0/ 1/2010	12/01/2000
	from the access site, inclusive of all imaging guidance and monitoring,	Clinical Review to avoid post-service review.		
	percutaneous; subsequent vein(s) treated in a single extremity, each	Clinical Review to avoid post-service review.		
	through separate access sites (List separately in addition to code for			
	primary procedure)			
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00022		Medical Policy Criteria. Submit for Recommended	1/ 1/ 1000	12/01/2000
		Clinical Review to avoid post-service review.		
36836	Percutaneous arteriovenous fistula creation, upper extremity, single	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
50050	access of both the peripheral artery and peripheral vein, including fistula	Not subject to pre-service review. Check EIU policy,	17 172023	12/31/2333
	maturation procedures (eg, transluminal balloon angioplasty, coil	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
	embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation			
36836	Percutaneous arteriovenous fistula creation, upper extremity, single	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
50050	access of both the peripheral artery and peripheral vein, including fistula	Not subject to pre-service review. Check EIU policy,	1/ 1/2023	12/31/2333
	maturation procedures (eg, transluminal balloon angioplasty, coil	which is one of our Clinical Payment and Coding		
	embolization) when performed, including all vascular access, imaging	Policy (CPCP).		
00007	guidance and radiologic supervision and interpretation	Fill Drease days to an increase the increase days the Dise	4/4/0000	40/04/0000
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	access sites of the peripheral artery and peripheral vein, including fistula	Not subject to pre-service review. Check EIU policy,		
	maturation procedures (eg, transluminal balloon angioplasty, coil	which is one of our Clinical Payment and Coding		
	embolization) when performed, including all vascular access, imaging	Policy (CPCP).		
0000 7	guidance and radiologic supervision and interpretation		4/4/0000	10/01/0000
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	access sites of the peripheral artery and peripheral vein, including fistula	Not subject to pre-service review. Check EIU policy,		
	maturation procedures (eg, transluminal balloon angioplasty, coil	which is one of our Clinical Payment and Coding		
	embolization) when performed, including all vascular access, imaging	Policy (CPCP).		
	guidance and radiologic supervision and interpretation			
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery,	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
	open or percutaneous, including angioplasty, when performed, and	Medical Policy Criteria. Submit for Recommended		
	radiological supervision and interpretation; with distal embolic protection	Clinical Review to avoid post-service review.		
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	open or percutaneous, including angioplasty, when performed, and	Medical Policy Criteria. Submit for Recommended		
	radiological supervision and interpretation; without distal embolic	Clinical Review to avoid post-service review.		
	protection			
37217	Transcatheter placement of intravascular stent(s), intrathoracic common	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
	carotid artery or innominate artery by retrograde treatment, open	Medical Policy Criteria. Submit for Recommended		
	ipsilateral cervical carotid artery exposure, including angioplasty, when	Clinical Review to avoid post-service review.		
	performed, and radiological supervision and interpretation			
37218	Transcatheter placement of intravascular stent(s), intrathoracic common	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	carotid artery or innominate artery, open or percutaneous antegrade	Medical Policy Criteria. Submit for Recommended		
	approach, including angioplasty, when performed, and radiological	Clinical Review to avoid post-service review.		
	supervision and interpretation			

37241	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping, and imaging	Medical Policy Criteria. Submit for Recommended		12/01/2000
	quidance necessary to complete the intervention; venous, other than	Clinical Review to avoid post-service review.		
	hemorrhage (eg, congenital or acquired venous malformations, venous			
	and capillary hemangiomas, varices, varicoceles)			
37242	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping, and imaging			
	guidance necessary to complete the intervention; arterial, other than	Clinical Review to avoid post-service review.		
	hemorrhage or tumor (eg, congenital or acquired arterial malformations,			
	arteriovenous malformations, arteriovenous fistulas, aneurysms,			
	pseudoaneurvsms)			
37243	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping, and imaging	Medical Policy Criteria. Submit for Recommended		
	guidance necessary to complete the intervention; for tumors, organ	Clinical Review to avoid post-service review.		
	ischemia, or infarction			
37244	Vascular embolization or occlusion, inclusive of all radiological	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	supervision and interpretation, intraprocedural roadmapping, and imaging	Medical Policy Criteria. Submit for Recommended		
l	guidance necessary to complete the intervention; for arterial or venous	Clinical Review to avoid post-service review.		
	hemorrhage or lymphatic extravasation			
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	(SEPS)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37700	Ligation and division of long saphenous vein at saphenofemoral junction,	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	or distal interruptions	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37718	Ligation, division, and stripping, short saphenous vein	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37722	Ligation, division, and stripping, long (greater) saphenous veins from	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	saphenofemoral junction to knee or below	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37735	Ligation and division and complete stripping of long or short saphenous	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	veins with radical excision of ulcer and skin graft and/or interruption of	Medical Policy Criteria. Submit for Recommended		
	communicating veins of lower leg, with excision of deep fascia	Clinical Review to avoid post-service review.		
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin		8/1/2006	12/31/2999
	graft, when performed, open,1 leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	guidance, when performed, 1 leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37780	Ligation and division of short saphenous vein at saphenopopliteal junction		8/1/2006	12/31/2999
	(separate procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	5 7 7 5	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37790	Penile venous occlusive procedure	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38204	Management of recipient hematopoietic progenitor cell donor search and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	······································	Clinical Review to avoid post-service review.		
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation,	MP Criteria: Procedure/service reviewed against	1/1/1950	1/31/2024
		Medical Policy Criteria. Submit for Recommended		
	, , ,	Clinical Review to avoid post-service review.		
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38208	Transplant preparation of hematopoietic progenitor cells; thawing of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38209	Transplant preparation of hematopoietic progenitor cells; thawing of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	previously frozen harvest, with washing, per donor	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38210	Transplant preparation of hematopoietic progenitor cells; specific cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	depletion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	removal	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38213	Transplant preparation of hematopoietic progenitor cells; platelet	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	depletion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	depletion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38215	Transplant preparation of hematopoietic progenitor cells; cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	concentration in plasma, mononuclear, or buffy coat layer	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38230	Bone marrow harvesting for transplantation; allogeneic	MP Criteria: Procedure/service reviewed against	1/1/1950	1/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38232	Bone marrow harvesting for transplantation; autologous	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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

43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
10200		Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric	MP Criteria: Procedure/service reviewed against	7/15/2016	12/31/2999
	fundoplasty, partial or complete, includes duodenoscopy when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	submucosal injection(s), any substance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020) 12/31/2999
	endomicroscopy	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	endomicroscopy	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal	MP Criteria: Procedure/service reviewed against	5/1/2010	12/31/2999
	energy to the muscle of lower esophageal sphincter and/or gastric cardia,	Medical Policy Criteria. Submit for Recommended		
	for treatment of gastroesophageal reflux disease	Clinical Review to avoid post-service review.		
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure,	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	placement of sphincter augmentation device (ie, magnetic band),	Medical Policy Criteria. Submit for Recommended		
	including cruroplasty when performed	Clinical Review to avoid post-service review.		
43289	Unlisted laparoscopy procedure, esophagus	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	3 12/31/2999
	intragastric bariatric balloon	Not subject to pre-service review. Check EIU policy,		
	, , , , , , , , , , , , , , , , , , ,	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intragastric bariatric balloon	Not subject to pre-service review. Check EIU policy,		
	, i i i i i i i i i i i i i i i i i i i	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	3 12/31/2999
	intragastric bariatric balloon(s)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intragastric bariatric balloon(s)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against	6/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
43645	and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Medical Policy Criteria. Submit for Recommended	11 11 2000	12/01/2000
		Clinical Review to avoid post-service review.		
	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	and small intestine reconstruction to limit absorption	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3770	Laparoscopy, surgical, gastric restrictive procedure; placement of	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
0110	adjustable gastric restrictive device (eg, gastric band and subcutaneous	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
	port components)	Clinical Review to avoid post-service review.		
3771			1/1/2006	12/31/2999
0111	gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
	gasule resultive device component only	Clinical Review to avoid post-service review.		
3772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable		1/1/2006	12/31/2999
5112		Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/31/2999
	gastric restrictive device component only	,		
0770		Clinical Review to avoid post-service review.	4/4/2000	10/01/0000
3773	Laparoscopy, surgical, gastric restrictive procedure; removal and	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	replacement of adjustable gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended		
0774		Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
3774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable	•	1/1/2006	12/31/2999
	gastric restrictive device and subcutaneous port components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	gastrectomy (ie, sleeve gastrectomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3842	Gastric restrictive procedure, without gastric bypass, for morbid obesity;	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	vertical-banded gastroplasty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3843	Gastric restrictive procedure, without gastric bypass, for morbid obesity;	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	other than vertical-banded gastroplasty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving	MP Criteria: Procedure/service reviewed against	9/15/2009	12/31/2999
	duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to	Medical Policy Criteria. Submit for Recommended		
	limit absorption (biliopancreatic diversion with duodenal switch)	Clinical Review to avoid post-service review.		
3846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	short limb (150 cm or less) Roux-en-Y gastroenterostomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	small intestine reconstruction to limit absorption	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3848	Revision, open, of gastric restrictive procedure for morbid obesity, other	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	than adjustable gastric restrictive device (separate procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3886	Gastric restrictive procedure, open; revision of subcutaneous port	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	component only	Medical Policy Criteria. Submit for Recommended		,,
		Clinical Review to avoid post-service review.		
3887	Gastric restrictive procedure, open; removal of subcutaneous port	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
0007		Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
		-		
		Clinical Review to avoid post-service review.		

43888	Gastric restrictive procedure, open; removal and replacement of	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	subcutaneous port component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
44705	Preparation of fecal microbiota for instillation, including assessment of	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	donor specimen	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
46707	Repair of anorectal fistula with plug (eg, porcine small intestine	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	12/31/2999
	submucosa [SIS])	Not subject to pre-service 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.	9/1/2020	12/31/2999
	submucosa [SIS])	Not subject to pre-service 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); radiofrequency		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. 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	11/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
	intraoperative ultrasound guidance and monitoring, if performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50360	Renal allotransplantation, implantation of graft; without recipient	MP Criteria: Procedure/service reviewed against	5/15/2016	12/31/2999
	nephrectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50541	Laparoscopy, surgical; ablation of renal cysts	MP Criteria: Procedure/service reviewed against	3/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	intraoperative ultrasound guidance and monitoring, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral,	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	radiofrequency	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
51715	Endoscopic injection of implant material into the submucosal tissues of	MP Criteria: Procedure/service reviewed against	5/1/2007	12/31/2999
	the urethra and/or bladder neck	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

52284	Cystourethroscopy, with mechanical urethral dilation and urethral	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	therapeutic drug delivery by drug-coated balloon catheter for urethral	Not subject to pre-service review. Check EIU policy,			
	stricture or stenosis, male, including fluoroscopy, when performed	which is one of our Clinical Payment and Coding Policy (CPCP).			
52284	Cystourethroscopy, with mechanical urethral dilation and urethral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	therapeutic drug delivery by drug-coated balloon catheter for urethral	Not subject to pre-service review. Check EIU policy,			
	stricture or stenosis, male, including fluoroscopy, when performed	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
52284	Cystourethroscopy, with mechanical urethral dilation and urethral	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	therapeutic drug delivery by drug-coated balloon catheter for urethral	Medical Policy Criteria. Submit for Recommended			
	stricture or stenosis, male, including fluoroscopy, when performed	Clinical Review to avoid post-service review.			
52327	Cystourethroscopy (including ureteral catheterization); with subureteric	MP Criteria: Procedure/service reviewed against	6/1/2017		12/31/2999
	injection of implant material	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015		12/31/2999
	implant; single implant	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015		12/31/2999
	implant; each additional permanent adjustable transprostatic implant (List	Medical Policy Criteria. Submit for Recommended			
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.			10/01/0000
53451	Periurethral transperineal adjustable balloon continence device; bilateral	EIU: Procedure/service not reimbursed by the Plan.		10/1/2024	12/31/2999
	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).	10/1/0001		10/04/0000
53451	Periurethral transperineal adjustable balloon continence device; bilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
52454	Devices there is a second a directable ballace continence devices bilateral	Policy (CPCP). MP Criteria: Procedure/service reviewed against	E/4/0004		0/20/2024
53451	Periurethral transperineal adjustable balloon continence device; bilateral		5/1/2024		9/30/2024
	insertion, including cystourethroscopy and imaging guidance	Medical Policy Criteria. Submit for Recommended			
53452	Derivertheal transportance adjustable bolloop continence devices unilateral	Clinical Review to avoid post-service review.		10/1/2024	12/31/2999
5545Z	Periurethral transperineal adjustable balloon continence device; unilateral	EIU: Procedure/service not reimbursed by the Plan.		10/1/2024	12/31/2999
	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
53452	Periurethral transperineal adjustable balloon continence device; unilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
JJ4JZ	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy,	10/1/2024		12/31/2999
	insertion, including cystolicethoscopy and imaging guidance	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
53452	Periurethral transperineal adjustable balloon continence device; unilateral	MP Criteria: Procedure/service reviewed against	5/1/2024		9/30/2024
50 7 52	insertion, including cystourethroscopy and imaging guidance	Medical Policy Criteria. Submit for Recommended	5/1/2024		5/50/2024
	insertion, including cystodrethroscopy and imaging guidance	Clinical Review to avoid post-service review.			
53453	Periurethral transperineal adjustable balloon continence device; removal,	EIU: Procedure/service not reimbursed by the Plan.		10/1/2024	12/31/2999
00400	each balloon	Not subject to pre-service review. Check EIU policy,		10/1/2024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
53453	Periurethral transperineal adjustable balloon continence device; removal,	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
00100	each balloon	Not subject to pre-service review. Check EIU policy,	10/1/2024		
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

53453	Periurethral transperineal adjustable balloon continence device; removal,	MP Criteria: Procedure/service reviewed against	5/1/2024	9/30/2024
	each balloon	Medical Policy Criteria. Submit for Recommended		0,00,2021
		Clinical Review to avoid post-service review.		
53454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53454	Periurethral transperineal adjustable balloon continence device;	MP Criteria: Procedure/service reviewed against	5/1/2024	9/30/2024
	percutaneous adjustment of balloon(s) fluid volume	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
53855	Insertion of a temporary prostatic urethral stent, including urethral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	measurement	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53855	Insertion of a temporary prostatic urethral stent, including urethral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	measurement	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53855	Insertion of a temporary prostatic urethral stent, including urethral	MP Criteria: Procedure/service reviewed against	10/15/2020	5/14/2024
	measurement	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
53860	Transurethral radiofrequency micro-remodeling of the female bladder	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	neck and proximal urethra for stress urinary incontinence	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).	0///0000	10/01/0000
53860	Transurethral radiofrequency micro-remodeling of the female bladder	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	neck and proximal urethra for stress urinary incontinence	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).	5///0000	10/01/0000
54125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F 4000	laisstine energiester fan Dermanisstine er e	Clinical Review to avoid post-service review.	40/45/0040	40/04/0000
54200	Injection procedure for Peyronie disease;	MP Criteria: Procedure/service reviewed against	12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F 400F	luisetien messedure fan Dermanie dieseser with erunieel ermaarun of elemen	Clinical Review to avoid post-service review.	40/45/0040	40/04/0000
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque		12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
54240	Penile plethysmography	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
04240			11/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F1100	Incortion of popula proothesia, populately (constrained)	Clinical Review to avoid post-service review.	1/1/1050	12/21/2000
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

54401	Insertion of penile prosthesis; inflatable (self-contained)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
54405	Insertion of multi-component, inflatable penile prosthesis, including	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
01100	placement of pump, cylinders, and reservoir	Medical Policy Criteria. Submit for Recommended	1, 1, 1000	12/01/2000
	placement of pump, cylinders, and reservoir	Clinical Review to avoid post-service review.		
54406	Removal of all components of a multi-component, inflatable penile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
34400	prosthesis without replacement of prosthesis	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1950	12/31/2999
	prostnesis without replacement of prostnesis	-		
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
54406		0	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F4440		Clinical Review to avoid post-service review.	4/4/4050	10/01/0000
54410	Removal and replacement of all component(s) of a multi-component,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	inflatable penile prosthesis at the same operative session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54411	Removal and replacement of all components of a multi-component	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	inflatable penile prosthesis through an infected field at the same operative			
	session, including irrigation and debridement of infected tissue	Clinical Review to avoid post-service review.		
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	prosthesis, without replacement of prosthesis	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	contained) penile prosthesis at the same operative session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	contained) penile prosthesis through an infected field at the same	Medical Policy Criteria. Submit for Recommended		
	operative session, including irrigation and debridement of infected tissue	Clinical Review to avoid post-service review.		
54660	Insertion of testicular prosthesis (separate procedure)	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
0.000		Medical Policy Criteria. Submit for Recommended	0, 1, 2000	,
		Clinical Review to avoid post-service review.		
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
00100	saturation sampling, including imaging guidance	Medical Policy Criteria. Submit for Recommended	11/10/2010	12/01/2000
	saturation sampling, including imaging guidance	Clinical Review to avoid post-service review.		
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and	MP Criteria: Procedure/service reviewed against	6/15/2007	12/31/2999
55675		5	0/13/2007	12/31/2999
	monitoring)	Medical Policy Criteria. Submit for Recommended		
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-	Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
00000		MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	focused ultrasound (HIFU), including ultrasound guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	4.4.4.10.0.4.7	10/01/0000
55899	Unlisted procedure, male genital system	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

56805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
0.20.		Medical Policy Criteria. Submit for Recommended	0, 1, 2000	
		Clinical Review to avoid post-service review.		
57292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
0.202		Medical Policy Criteria. Submit for Recommended	0, 1, 2000	
		Clinical Review to avoid post-service review.		
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
01200	approach	Medical Policy Criteria. Submit for Recommended	1/ 1/2001	12/01/2000
	approach	Clinical Review to avoid post-service review.		
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
01000		Medical Policy Criteria. Submit for Recommended	5/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
57420	approach	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/31/2333
	approach	Clinical Review to avoid post-service review.		
58321	Artificial insemination; intra-cervical	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
50321			1/1/1950	12/31/2999
50000	Autificial incomplexitions induces staning	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	4/4/4050	40/04/0000
58322	Artificial insemination; intra-uterine	,	1/1/1950	12/31/2999
50000	On any constitution for antificial in a contraction	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58323	Sperm washing for artificial insemination	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
50500	To a second set of the first of the side of the second set of the side of the	Plan. Not subject to pre-service review.	0/45/0004	40/04/0000
58580	Transcervical ablation of uterine fibroid(s), including intraoperative	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	ultrasound guidance and monitoring, radiofrequency	Medical Policy Criteria. Submit for Recommended		
50750		Clinical Review to avoid post-service review.	4.45.0000	10/01/0000
58750	Tubotubal anastomosis	Non Covered: Procedure/service not covered by the	1/15/2008	12/31/2999
		Plan. Not subject to pre-service review.	10///0000	1010110000
59072	Fetal umbilical cord occlusion, including ultrasound guidance	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis),	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
	including ultrasound guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
59076	Fetal shunt placement, including ultrasound guidance	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
60699	Unlisted procedure, endocrine system	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis),	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	percutaneous	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis),	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	percutaneous	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
61635	Transcatheter placement of intravascular stent(s), intracranial (eg,	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	atherosclerotic stenosis), including balloon angioplasty, if performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	infusion for thrombolysis, intracranial, any method, including diagnostic	Medical Policy Criteria. Submit for Recommended		
	angiography, fluoroscopic guidance, catheter placement, and	Clinical Review to avoid post-service review.		
	intraprocedural pharmacological thrombolytic injection(s)			
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	burr hole(s), with magnetic resonance imaging guidance, when	Medical Policy Criteria. Submit for Recommended		
	performed; single trajectory for 1 simple lesion	Clinical Review to avoid post-service review.		
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	burr hole(s), with magnetic resonance imaging guidance, when	Medical Policy Criteria. Submit for Recommended		
	performed; multiple trajectories for multiple or complex lesion(s)	Clinical Review to avoid post-service review.		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List	MP Criteria: Procedure/service reviewed against	5/15/2024	6/30/2024
	separately in addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	receiver, including craniectomy or craniotomy, when performed, with	Medical Policy Criteria. Submit for Recommended		
	direct or inductive coupling, with connection to depth and/or cortical strip	Clinical Review to avoid post-service review.		
	electrode array(s)			
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	generator or receiver with connection to depth and/or cortical strip	Medical Policy Criteria. Submit for Recommended		
	electrode array(s)	Clinical Review to avoid post-service review.		
61892	Removal of skull-mounted cranial neurostimulator pulse generator or	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	receiver with cranioplasty, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
62263	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 2 or more days	Policy (CPCP).		
62263	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 2 or more days	Policy (CPCP).		
62264	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 1 day	Policy (CPCP).		

62264	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 1 day	Policy (CPCP).		
62287	Decompression procedure, percutaneous, of nucleus pulposus of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	3 12/31/2999
	intervertebral disc, any method utilizing needle based technique to	Not subject to pre-service review. Check EIU policy,		
	remove disc material under fluoroscopic imaging or other form of indirect	which is one of our Clinical Payment and Coding		
	visualization, with discography and/or epidural injection(s) at the treated	Policy (CPCP).		
	level(s), when performed, single or multiple levels, lumbar			
62287	Decompression procedure, percutaneous, of nucleus pulposus of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intervertebral disc, any method utilizing needle based technique to	Not subject to pre-service review. Check EIU policy,		
	remove disc material under fluoroscopic imaging or other form of indirect	which is one of our Clinical Payment and Coding		
	visualization, with discography and/or epidural injection(s) at the treated	Policy (CPCP).		
	level(s), when performed, single or multiple levels, lumbar			
64555	Percutaneous implantation of neurostimulator electrode array; peripheral	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	nerve (excludes sacral nerve)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	treatment, includes programming	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	electrode array and pulse generator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64575	Open implantation of neurostimulator electrode array; peripheral nerve	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(excludes sacral nerve)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse	MP Criteria: Procedure/service reviewed against	5/1/2022	3/14/2024
	generator, and distal respiratory sensor electrode or electrode array	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	pulse generator or receiver, requiring pocket creation and connection	Medical Policy Criteria. Submit for Recommended		
	between electrode array and pulse generator or receiver	Clinical Review to avoid post-service review.		
64596	Insertion or replacement of percutaneous electrode array, peripheral	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nerve, with integrated neurostimulator, including imaging guidance, when	Medical Policy Criteria. Submit for Recommended		
	performed; initial electrode array	Clinical Review to avoid post-service review.		
64597	Insertion or replacement of percutaneous electrode array, peripheral	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nerve, with integrated neurostimulator, including imaging guidance, when	Medical Policy Criteria. Submit for Recommended		
	performed; each additional electrode array (List separately in addition to	Clinical Review to avoid post-service review.		
	code for primary procedure)			
64624	Destruction by neurolytic agent, genicular nerve branches including	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	imaging guidance, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64628	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	2 12/31/2999
	imaging guidance; first 2 vertebral bodies, lumbar or sacral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
64628	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	imaging guidance; first 2 vertebral bodies, lumbar or sacral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

64629	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
01020	imaging guidance; each additional vertebral body, lumbar or sacral (List	Not subject to pre-service review. Check EIU policy,	0/ 1/2022	12/01/2000
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
64629	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	imaging guidance; each additional vertebral body, lumbar or sacral (List	Not subject to pre-service review. Check EIU policy,		
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
64640	Destruction by neurolytic agent; other peripheral nerve or branch	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64809	Sympathectomy, thoracolumbar	MP Criteria: Procedure/service reviewed against	5/19/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65760	Keratomileusis	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65772	Corneal relaxing incision for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
l		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65775	Corneal wedge resection for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
	retention of device or stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
	retention of device or stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66179	Aqueous shunt to extraocular equatorial plate reservoir, external	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	approach; without graft	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	5///000/	10/01/0000
66180	Aqueous shunt to extraocular equatorial plate reservoir, external	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	approach; with graft	Medical Policy Criteria. Submit for Recommended		
22422		Clinical Review to avoid post-service review.	4/4/0044	10/01/0000
66183	Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	extraocular reservoir, external approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

66989	Extracapsular cataract removal with insertion of intraocular lens	MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
	prosthesis (1-stage procedure), manual or mechanical technique (eg,	Medical Policy Criteria. Submit for Recommended	5/15/2022	12/01/2000
	irrigation and aspiration or phacoemulsification), complex, requiring	Clinical Review to avoid post-service review.		
	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			
66991	Extracapsular cataract removal with insertion of intraocular lens	MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
	prosthesis (1 stage procedure), manual or mechanical technique (eg,	Medical Policy Criteria. Submit for Recommended		
	irrigation and aspiration or phacoemulsification); with insertion of	Clinical Review to avoid post-service review.		
	intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal)			
	anterior segment aqueous drainage device, without extraocular reservoir,			
	internal approach, one or more			
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against	8/15/2023	1/31/2024
l		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67516	Suprachoroidal space injection of pharmacologic agent (separate	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	MP Criteria: Procedure/service reviewed against	9/24/2012	2/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	material (eg, banked fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67902	Repair of blepharoptosis; frontalis muscle technique with autologous	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	fascial sling (includes obtaining fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67903	Repair of blepharoptosis; (tarso) levator resection or advancement,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	internal approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67904	Repair of blepharoptosis; (tarso) levator resection or advancement,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	external approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67906	Repair of blepharoptosis; superior rectus technique with fascial sling	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	(includes obtaining fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	resection (eg, Fasanella-Servat type)	Medical Policy Criteria. Submit for Recommended		
00000		Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
69090	Ear piercing	Non Covered: Procedure/service not covered by the	1/1/2020	12/31/2999
00000		Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
69300	Otoplasty, protruding ear, with or without size reduction	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	dilation); unilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
69706		MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	dilation); bilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
69716	Implantation, osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed against	12/15/2022	12/31/2999
	transcutaneous attachment to external speech processor, within the	Medical Policy Criteria. Submit for Recommended		
	mastoid and/or resulting in removal of less than 100 sq mm surface area	Clinical Review to avoid post-service review.		
	of bone deep to the outer cranial cortex			
69719	Replacement (including removal of existing device), osseointegrated	MP Criteria: Procedure/service reviewed against	12/15/2022	12/31/2999
	implant, skull; with magnetic transcutaneous attachment to external	Medical Policy Criteria. Submit for Recommended		
	speech processor, within the mastoid and/or involving a bony defect less	Clinical Review to avoid post-service review.		
	than 100 sq mm surface area of bone deep to the outer cranial cortex			
69728	Removal, entire osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
	transcutaneous attachment to external speech processor, outside the	Medical Policy Criteria. Submit for Recommended		
	mastoid and involving a bony defect greater than or equal to 100 sq mm	Clinical Review to avoid post-service review.		
	surface area of bone deep to the outer cranial cortex			
69729	Implantation, osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
	transcutaneous attachment to external speech processor, outside of the	Medical Policy Criteria. Submit for Recommended		
	mastoid and resulting in removal of greater than or equal to 100 sq mm	Clinical Review to avoid post-service review.		
	surface area of bone deep to the outer cranial cortex			
69730	Replacement (including removal of existing device), osseointegrated	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
	implant, skull; with magnetic transcutaneous attachment to external	Medical Policy Criteria. Submit for Recommended		
	speech processor, outside the mastoid and involving a bony defect	Clinical Review to avoid post-service review.		
	greater than or equal to 100 sq mm surface area of bone deep to the			
	outer cranial cortex			
76120	Cineradiography/videoradiography, except where specifically included	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
76125	Cineradiography/videoradiography to complement routine examination	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	(List separately in addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
82523	Collagen cross links, any method	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
82523	Collagen cross links, any method	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83695	Lipoprotein (a)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

83695	Lipoprotein (a)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	20 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83701	Lipoprotein, blood; high resolution fractionation and quantitation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	20 12/31/2999
	lipoproteins including lipoprotein subclasses when performed (eg,	Not subject to pre-service review. Check EIU policy,		
	electrophoresis, ultracentrifugation)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83701	Lipoprotein, blood; high resolution fractionation and quantitation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	lipoproteins including lipoprotein subclasses when performed (eg,	Not subject to pre-service review. Check EIU policy,		
	electrophoresis, ultracentrifugation)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	20 12/31/2999
	nuclear magnetic resonance spectroscopy), includes lipoprotein particle	Not subject to pre-service review. Check EIU policy,		
	subclass(es), when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	nuclear magnetic resonance spectroscopy), includes lipoprotein particle	Not subject to pre-service review. Check EIU policy,		
	subclass(es), when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	20 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	20 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
83987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan.	12/1/20	20 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

83987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg,	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12],	Not subject to pre-service review. Check EIU policy,			
	alpha-fetoprotein), qualitative, each specimen	which is one of our Clinical Payment and Coding			
		Policy (CPCP)			
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg,	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12],	Not subject to pre-service review. Check EIU policy,			
	alpha-fetoprotein), qualitative, each specimen	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		6/1/2023	12/31/2999
	semiquantitative, single-step method (eg, reagent strip); severe acute	Not subject to pre-service review. Check EIU policy,			
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease	which is one of our Clinical Payment and Coding			
	[COVID-19])	Policy (CPCP).	0.11/00.00		10/01/0000
86328	Immunoassay for infectious agent antibody(ies), qualitative or	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023		12/31/2999
	semiquantitative, single-step method (eg, reagent strip); severe acute	Not subject to pre-service review. Check EIU policy,			
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease	which is one of our Clinical Payment and Coding			
00040	[COVID-19])	Policy (CPCP).		40/4/0000	40/04/0000
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
86343	Leukocyte histamine release test (LHR)	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
00343	Leukocyte histannine release test (LHK)	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
		which is one of our Clinical Payment and Coding			
06252	lumphonito transformation, mitagon (nhutamitagon) as antigas induced	Policy (CPCP).	1/1/1950		12/31/2999
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
	blastogenesis	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
00400	(SARS-CoV-2) (coronavirus disease [COVID-19]); screen	Not subject to pre-service review. Check EIU policy,	0/1/2023	12/31/2999
	(SARS-COV-2) (COIOIIAVIIUS UISEASE [COVID-19]), SCIEEII	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
00400	(SARS-CoV-2) (coronavirus disease [COVID-19]); screen	Not subject to pre-service review. Check EIU policy,	0/1/2023	12/31/2999
	(SARS-Cov-2) (coronavirus disease [COVID-19]); screen			
		which is one of our Clinical Payment and Coding		
00400		Policy (CPCP).	0/4/0000	40/04/0000
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3 12/31/2999
	(SARS-CoV-2) (coronavirus disease [COVID-19]); titer	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
<u></u>		Policy (CPCP).	01110000	10/01/0000
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	(SARS-CoV-2) (coronavirus disease [COVID-19]); titer	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3 12/31/2999
	(coronavirus disease [COVID-19]) antibody, quantitative	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	(coronavirus disease [COVID-19]) antibody, quantitative	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3 12/31/2999
	2) (coronavirus disease [COVID-19])	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	2) (coronavirus disease [COVID-19])	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
86911	Blood typing, for paternity testing, per individual; each additional antigen	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	system	Plan. Not subject to pre-service review.		
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal	MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	Giardia), includes multiplex reverse transcription, when performed, and	Clinical Review to avoid post-service review.		
	multiplex amplified probe technique, multiple types or subtypes, 3-5			
	targets			
87506		MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus,			
	Giardia), includes multiplex reverse transcription, when performed, and	Clinical Review to avoid post-service review.		
	multiplex amplified probe technique, multiple types or subtypes, 6-11			
	targets		1	

87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal	MD Criteria: Dreadure/convice reviewed erginet	3/15/2020	12/31/2999
87507		MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus,	Medical Policy Criteria. Submit for Recommended		
	Giardia), includes multiplex reverse transcription, when performed, and	Clinical Review to avoid post-service review.		
	multiplex amplified probe technique, multiple types or subtypes, 12-25			
88000	targets Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	hooropsy (autopsy), gross sxamination only, without one	Plan. Not subject to pre-service review.	17 17 10000	12/01/2000
88005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	1, 1, 10000	12/01/2000
88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	., .,	12/01/2000
88012	Necropsy (autopsy), gross examination only; infant with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	······································	Plan. Not subject to pre-service review.		
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	brain	Plan. Not subject to pre-service review.		
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88025	Necropsy (autopsy), gross and microscopic; with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88027	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88028	Necropsy (autopsy), gross and microscopic; infant with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	brain	Plan. Not subject to pre-service review.		
88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88040	Necropsy (autopsy); forensic examination	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88045	Necropsy (autopsy); coroner's call	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88099	Unlisted necropsy (autopsy) procedure	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
88375	Optical endomicroscopic image(s), interpretation and report, real-time or	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	referred, each endoscopic session	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
88375	Optical endomicroscopic image(s), interpretation and report, real-time or	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	referred, each endoscopic session	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
89258	Cryopreservation; embryo(s)	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
		Plan. Not subject to pre-service review.		
89259	Cryopreservation; sperm	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
		Plan. Not subject to pre-service review.		

89335	Cryopreservation, reproductive tissue, testicular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89337	Cryopreservation, mature oocyte(s)	Non Covered: Procedure/service not covered by the	1/1/2019	12/31/2999
59557	Cryopreservation, mature obcyte(s)	Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
9342	Storage (per year); embryo(s)	Non Covered: Procedure/service not covered by the	3/20/2018	12/31/2999
		Plan. Not subject to pre-service review.		
9343	Storage (per year); sperm/semen	Non Covered: Procedure/service not covered by the	3/20/2018	12/31/2999
		Plan. Not subject to pre-service review.		
39344	Storage (per year); reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
9346	Storage (per year); oocyte(s)	Non Covered: Procedure/service not covered by the	3/20/2018	12/31/2999
		Plan. Not subject to pre-service review.		
9352	Thawing of cryopreserved; embryo(s)	Non Covered: Procedure/service not covered by the	3/20/2018	12/31/2999
		Plan. Not subject to pre-service review.		
39353	Thawing of cryopreserved; sperm/semen, each aliquot	Non Covered: Procedure/service not covered by the	3/20/2018	12/31/2999
		Plan. Not subject to pre-service review.		
39354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
9356	Thawing of cryopreserved; oocytes, each aliquot	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
0378	Respiratory syncytial virus, monoclonal antibody, recombinant, for	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	intramuscular use, 50 mg, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0666	Influenza virus vaccine (IIV), pandemic formulation, split virus,	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	preservative free, for intramuscular use	Plan. Not subject to pre-service review.		
0667	Influenza virus vaccine (IIV), pandemic formulation, split virus,	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	adjuvanted, for intramuscular use	Plan. Not subject to pre-service review.		
0668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	intramuscular use	Plan. Not subject to pre-service review.		
0683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for	Non Covered: Procedure/service not covered by the	1/1/2024	5/31/2024
	intramuscular use	Plan. Not subject to pre-service review.		
0867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	initial, including cortical mapping, motor threshold determination, delivery	Medical Policy Criteria. Submit for Recommended		
	and management	Clinical Review to avoid post-service review.		
0868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	subsequent delivery and management, per session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	subsequent motor threshold re-determination with delivery and	Medical Policy Criteria. Submit for Recommended		
	management	Clinical Review to avoid post-service review.		
0875	Individual psychophysiological therapy incorporating biofeedback training	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	by any modality (face-to-face with the patient), with psychotherapy (eg,	Medical Policy Criteria. Submit for Recommended		
	insight oriented, behavior modifying or supportive psychotherapy); 30	Clinical Review to avoid post-service review.		
	minutes			
0876	Individual psychophysiological therapy incorporating biofeedback training	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	by any modality (face-to-face with the patient), with psychotherapy (eg,	Medical Policy Criteria. Submit for Recommended		
	insight oriented, behavior modifying or supportive psychotherapy); 45	Clinical Review to avoid post-service review.		
	minutes		1	

90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/1950	5/31/2024
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for	Clinical Review to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
90889	medical diagnostic purposes Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
90901	individuals, agencies, or insurance carriers Biofeedback training by any modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	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.	4/1/2021	12/31/2999
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	0 12/31/2999
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	0 12/31/2999
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	0 12/31/2999
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy),	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	colon, with interpretation and report	Not subject to pre-service review. Check EIU policy,		1/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding Policy (CPCP).			
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy),	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	colon, with interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
91117			11/15/2023		12/31/2999
	(including provocation tests, eg, meal, intracolonic balloon distension,	Medical Policy Criteria. Submit for Recommended			
	pharmacologic agents, if performed), with interpretation and report	Clinical Review to avoid post-service review.			
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan.	9	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
01100		Policy (CPCP).		14/0000	40/04/0000
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
91133	Electrogastrography, diagnostic, transcutaneous, with provocative testing	Not subject to pre-service review. Check EIU policy,	9/1/2020		12/31/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92065	Orthoptic training; performed by a physician or other qualified health care	Non Covered: Procedure/service not covered by the	11/1/2013		12/31/2999
	professional	Plan. Not subject to pre-service review.			
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment,	EIU: Procedure/service not reimbursed by the Plan.	(9/1/2020	12/31/2999
	with interpretation and report, unilateral or bilateral	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92132			9/1/2020		12/31/2999
	with interpretation and report, unilateral or bilateral	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
00445		Policy (CPCP).			10/01/0000
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or	EIU: Procedure/service not reimbursed by the Plan.	12	2/1/2020	12/31/2999
	bilateral, with interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	bilateral, with interpretation and report	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/01/2000
		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.	9	9/1/2020	12/31/2999
		Not subject to pre-service 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.	9/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/	/15/2021	12/31/2999
	and report; cervical (cVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
	and report; cervical (cVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/	/15/2021	12/31/2999
	and report; ocular (oVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
	and report; ocular (oVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
005/0		Policy (CPCP).			10/01/0000
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/	/15/2021	12/31/2999
	and report; cervical (cVEMP) and ocular (oVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
00540		Policy (CPCP).	E/4E/0004		40/04/0000
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
	and report; cervical (cVEMP) and ocular (oVEMP)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
92548	Computerized dynamic posturography sensory organization test (CDP-	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	1.	2/1/2020	12/31/2999
92340	SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform	Not subject to pre-service review. Check EIU policy,	1	2/1/2020	12/31/2999
	sway, eyes closed platform sway, platform and visual sway), including	which is one of our Clinical Payment and Coding			
	interpretation and report;	Policy (CPCP).			
92548	Computerized dynamic posturography sensory organization test (CDP-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
02040	SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/01/2000
	sway, eyes closed platform sway, platform and visual sway), including	which is one of our Clinical Payment and Coding			
	interpretation and report;	Policy (CPCP).			
92549	Computerized dynamic posturography sensory organization test (CDP-	EIU: Procedure/service not reimbursed by the Plan.	1:	2/1/2020	12/31/2999
	SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform	Not subject to pre-service review. Check EIU policy,			
	sway, eyes closed platform sway, platform and visual sway), including	which is one of our Clinical Payment and Coding			
	interpretation and report; with motor control test (MCT) and adaptation	Policy (CPCP).			
	test (ADT)	· ···· y (•· •·)·			
92549	Computerized dynamic posturography sensory organization test (CDP-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform	Not subject to pre-service review. Check EIU policy,			
	sway, eyes closed platform sway, platform and visual sway), including	which is one of our Clinical Payment and Coding			
	interpretation and report; with motor control test (MCT) and adaptation	Policy (CPCP).			
	test (ADT)				
92622	Diagnostic analysis, programming, and verification of an auditory	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	osseointegrated sound processor, any type; first 60 minutes	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

92623	Diagnostic analysis, programming, and verification of an auditory	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	osseointegrated sound processor, any type; each additional 15 minutes	Medical Policy Criteria. Submit for Recommended			
	(List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.			
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	to code for primary procedure)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
93050	Arterial pressure waveform analysis for assessment of central arterial	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	pressures, includes obtaining waveform(s), digitization and application of	Not subject to pre-service review. Check EIU policy,			
	nonlinear mathematical transformations to determine central arterial	which is one of our Clinical Payment and Coding			
	pressures and augmentation index, with interpretation and report, upper	Policy (CPCP).			
	extremity artery, non-invasive				
93050	Arterial pressure waveform analysis for assessment of central arterial	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	pressures, includes obtaining waveform(s), digitization and application of	Not subject to pre-service review. Check EIU policy,			
	nonlinear mathematical transformations to determine central arterial	which is one of our Clinical Payment and Coding			
	pressures and augmentation index, with interpretation and report, upper	Policy (CPCP).			
	extremity artery, non-invasive				
93150	Therapy activation of implanted phrenic nerve stimulator system,	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	including all interrogation and programming	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93150	Therapy activation of implanted phrenic nerve stimulator system,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	including all interrogation and programming	Not subject to pre-service review. Check EIU policy,			
	5 5 1 5 5	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93150	Therapy activation of implanted phrenic nerve stimulator system,	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	including all interrogation and programming	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
93151	Interrogation and programming (minimum one parameter) of implanted	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	phrenic nerve stimulator system	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93151	Interrogation and programming (minimum one parameter) of implanted	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	phrenic nerve stimulator system	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93151	Interrogation and programming (minimum one parameter) of implanted	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	phrenic nerve stimulator system	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
93152	Interrogation and programming of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	system during polysomnography	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93152	Interrogation and programming of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	system during polysomnography	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
93152	Interrogation and programming of implanted phrenic nerve stimulator	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	system during polysomnography	Medical Policy Criteria. Submit for Recommended	1		
		Clinical Review to avoid post-service review.			

93153	Interrogation without programming of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	system	Not subject to pre-service review. Check EIU policy,	0,10,202	
	,	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93153	Interrogation without programming of implanted phrenic nerve stimulator	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	system	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93153	Interrogation without programming of implanted phrenic nerve stimulator	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93228	External mobile cardiovascular telemetry with electrocardiographic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	recording, concurrent computerized real time data analysis and greater	Medical Policy Criteria. Submit for Recommended		
	than 24 hours of accessible ECG data storage (retrievable with query)	Clinical Review to avoid post-service review.		
	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			
93229	External mobile cardiovascular telemetry with electrocardiographic	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	recording, concurrent computerized real time data analysis and greater	Medical Policy Criteria. Submit for Recommended		
	than 24 hours of accessible ECG data storage (retrievable with query)	Clinical Review to avoid post-service review.		
	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			
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up		10/1/2019	12/31/2999
	to 30 days, including at least weekly downloads of pulmonary artery	Medical Policy Criteria. Submit for Recommended		
	pressure recordings, interpretation(s), trend analysis, and report(s) by a	Clinical Review to avoid post-service review.		
00500	physician or other qualified health care professional			10/01/0000
93580	Percutaneous transcatheter closure of congenital interatrial	MP Criteria: Procedure/service reviewed against	4/1/2005	12/31/2999
	communication (ie, Fontan fenestration, atrial septal defect) with implant	Medical Policy Criteria. Submit for Recommended		
00000	Freehouting of a sufficiency of a first first first of the fill to be a sufficiency of the	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
93660	Evaluation of cardiovascular function with tilt table evaluation, with	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	continuous ECG monitoring and intermittent blood pressure monitoring,	Medical Policy Criteria. Submit for Recommended		
93702	with or without pharmacological intervention Bioimpedance spectroscopy (BIS), extracellular fluid analysis for	Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan.	12/1/202	12/31/2999
93702	lymphedema assessment(s)	Not subject to pre-service review. Check EIU policy,	12/1/202	12/31/2999
	iymphedema assessmeni(s)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
00102	lymphedema assessment(s)	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
93740	Temperature gradient studies	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	12/31/2999
		Not subject to pre-service review. Check EIU policy,	5/ 1/202	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

93740	Temperature gradient studies	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
94014	reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review 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/	/1/2020	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	trend analysis, and periodic recalibration)	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	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	and interpretation only by a physician or other qualified health 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).	9/1/2020		12/31/2999
94452	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	-	12/31/2999
94453		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005		12/31/2999
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/	/1/2020	12/31/2999
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		12/31/2999
95065		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/	/1/2020	12/31/2999

95065	Direct nasal mucous membrane test	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
95700	Electroencephalogram (EEG) continuous recording, with video when	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	performed, setup, patient education, and takedown when performed,	Medical Policy Criteria. Submit for Recommended		
	administered in person by EEG technologist, minimum of 8 channels	Clinical Review to avoid post-service review.		
95705	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; unmonitored	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95706	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; with intermittent monitoring	Medical Policy Criteria. Submit for Recommended		
	and maintenance	Clinical Review to avoid post-service review.		
95707	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; with continuous, real-time	Medical Policy Criteria. Submit for Recommended		
	monitoring and maintenance	Clinical Review to avoid post-service review.		
95708	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours;	Medical Policy Criteria. Submit for Recommended		
	unmonitored	Clinical Review to avoid post-service review.		
5709	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours; with	Medical Policy Criteria. Submit for Recommended		
	intermittent monitoring and maintenance	Clinical Review to avoid post-service review.		
5710	Electroencephalogram (EEG), without video, review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours; with	Medical Policy Criteria. Submit for Recommended		
	continuous, real-time monitoring and maintenance	Clinical Review to avoid post-service review.		
5711	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; unmonitored	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95712	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; with intermittent monitoring	Medical Policy Criteria. Submit for Recommended		
	and maintenance	Clinical Review to avoid post-service review.		
5713	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, 2-12 hours; with continuous, real-time	Medical Policy Criteria. Submit for Recommended		
	monitoring and maintenance	Clinical Review to avoid post-service review.		
95714	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours;	Medical Policy Criteria. Submit for Recommended		
	unmonitored	Clinical Review to avoid post-service review.		
5715	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours; with	Medical Policy Criteria. Submit for Recommended		
	intermittent monitoring and maintenance	Clinical Review to avoid post-service review.		
5716	Electroencephalogram with video (VEEG), review of data, technical	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	description by EEG technologist, each increment of 12-26 hours; with	Medical Policy Criteria. Submit for Recommended		
	continuous, real-time monitoring and maintenance	Clinical Review to avoid post-service review.		
95717	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	spike and seizure detection, interpretation and report, 2-12 hours of EEG	Clinical Review to avoid post-service review.		
	recording; without video			

95718	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	spike and seizure detection, interpretation and report, 2-12 hours of EEG	Clinical Review to avoid post-service review.		
	recording; with video (VEEG)			
95719	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	spike and seizure detection, each increment of greater than 12 hours, up	Clinical Review to avoid post-service review.		
	to 26 hours of EEG recording, interpretation and report after each 24-hour			
	period: without video			
5720	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		,
	spike and seizure detection, each increment of greater than 12 hours, up	Clinical Review to avoid post-service review.		
	to 26 hours of EEG recording, interpretation and report after each 24-hour			
	period; with video (VEEG)			
5721	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
0121	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	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 or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
5122	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	spike and seizure detection, interpretation, and summary report, complete			
	study; greater than 36 hours, up to 60 hours of EEG recording, with video	Cirrical Review to avoid post-service review.		
	(VEEG)			
5723	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	gualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	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 or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	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 or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	spike and seizure detection, interpretation, and summary report, complete			
	study, greater than 84 hours of EEG recording, without video			
5726	Electroencephalogram (EEG), continuous recording, physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional review of recorded events, analysis of	Medical Policy Criteria. Submit for Recommended		
	spike and seizure detection, interpretation, and summary report, complete	Clinical Review to avoid post-service review.		
	study; greater than 84 hours of EEG recording, with video (VEEG)	·		
5803	Actigraphy testing, recording, analysis, interpretation, and report	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	(minimum of 72 hours to 14 consecutive days of recording)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
5803	Actigraphy testing, recording, analysis, interpretation, and report	MP Criteria: Procedure/service reviewed against	10/1/2019	9/30/2024
	(minimum of 72 hours to 14 consecutive days of recording)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

95905	Motor and/or sensory nerve conduction, using preconfigured electrode	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	array(s), amplitude and latency/velocity study, each limb, includes F-wave		5/1/2020	12/01/2000
	study when performed, with interpretation and report	which is one of our Clinical Payment and Coding		
	study when performed, with interpretation and report	Policy (CPCP).		
95905	Motor and/or sensory nerve conduction, using preconfigured electrode	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	array(s), amplitude and latency/velocity study, each limb, includes F-wave	Not subject to pre-service review. Check EIU policy,		
	study when performed, with interpretation and report	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
95919		EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	professional interpretation and report, unilateral or bilateral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
95919	Quantitative pupillometry with physician or other qualified health care	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	professional interpretation and report, unilateral or bilateral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
95954	Pharmacological or physical activation requiring physician or other	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	qualified health care professional attendance during EEG recording of	Medical Policy Criteria. Submit for Recommended		
	activation phase (eg, thiopental activation test)	Clinical Review to avoid post-service review.		
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	analysis)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95961	Functional cortical and subcortical mapping by stimulation and/or	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	recording of electrodes on brain surface, or of depth electrodes, to	Medical Policy Criteria. Submit for Recommended		
	provoke seizures or identify vital brain structures; initial hour of	Clinical Review to avoid post-service review.		
	attendance by a physician or other qualified health care professional			
95962	Functional cortical and subcortical mapping by stimulation and/or	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	recording of electrodes on brain surface, or of depth electrodes, to	Medical Policy Criteria. Submit for Recommended		
	provoke seizures or identify vital brain structures; each additional hour of	Clinical Review to avoid post-service review.		
	attendance by a physician or other qualified health care professional (List			
05005	separately in addition to code for primary procedure)		4/4/0000	40/04/0000
95965	Magnetoencephalography (MEG), recording and analysis; for	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	spontaneous brain magnetic activity (eg, epileptic cerebral cortex	Medical Policy Criteria. Submit for Recommended		
05000	localization)	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
95966	Magnetoencephalography (MEG), recording and analysis; for evoked	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
05007	cortex localization)	Clinical Review to avoid post-service review.	4/4/0000	12/31/2999
95967	Magnetoencephalography (MEG), recording and analysis; for evoked	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	or visual cortex localization) (List separately in addition to code for primary	Clinical Review to avoid post-service review.		
95981	procedure) Electronic analysis of implanted neurostimulator pulse generator system	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
30301	(eg, rate, pulse amplitude and duration, configuration of wave form,	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12131/2999
	battery status, electrode selectability, output modulation, cycling,	Clinical Review to avoid post-service review.		
	impedance and patient measurements) gastric neurostimulator pulse			
	generator/transmitter; subsequent, without reprogramming			

95982	Electronic analysis of implanted neurostimulator pulse generator system	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	(eg, rate, pulse amplitude and duration, configuration of wave form,	Medical Policy Criteria. Submit for Recommended	., ., _0000	12/01/2000
	battery status, electrode selectability, output modulation, cycling,	Clinical Review to avoid post-service review.		
	impedance and patient measurements) gastric neurostimulator pulse			
	generator/transmitter; subsequent, with reprogramming			
96000	Comprehensive computer-based motion analysis by video-taping and 3D	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	kinematics;	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96001	Comprehensive computer-based motion analysis by video-taping and 3D	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	kinematics; with dynamic plantar pressure measurements during walking	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96002	Dynamic surface electromyography, during walking or other functional	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	activities, 1-12 muscles	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96003	Dynamic fine wire electromyography, during walking or other functional	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	activities, 1 muscle	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96004	Review and interpretation by physician or other qualified health care	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	professional of comprehensive computer-based motion analysis, dynamic			
	plantar pressure measurements, dynamic surface electromyography	Clinical Review to avoid post-service review.		
	during walking or other functional activities, and dynamic fine wire			
	electromyography, with written report			
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	procedure, including separate incision(s) and closure, when performed;	Medical Policy Criteria. Submit for Recommended		
	first 60 minutes (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	procedure, including separate incision(s) and closure, when performed;	Medical Policy Criteria. Submit for Recommended		
	each additional 30 minutes (List separately in addition to code for primary	Clinical Review to avoid post-service review.		
	procedure)			
96571	Photodynamic therapy by endoscopic application of light to ablate	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	abnormal tissue via activation of photosensitive drug(s); each additional	Medical Policy Criteria. Submit for Recommended		
	15 minutes (List separately in addition to code for endoscopy or	Clinical Review to avoid post-service review.		
	bronchoscopy procedures of lung and gastrointestinal tract)			
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	MP Criteria: Procedure/service reviewed against	8/15/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	photoresponsive dermatoses requiring at least 4-8 hours of care under	Medical Policy Criteria. Submit for Recommended		
	direct supervision of the physician (includes application of medication and	Clinical Review to avoid post-service review.		
	dressings)			
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie,	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nonthermal and non-ablative) for post-operative pain reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97545	Work hardening/conditioning; initial 2 hours	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97546	Work hardening/conditioning; each additional hour (List separately in	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

97610	Low frequency, non-contact, non-thermal ultrasound, including topical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
37010	application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	3/1/2020	12/3 1/2999
		Policy (CPCP).		
97610	Low frequency, non-contact, non-thermal ultrasound, including topical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	application(s), when performed, wound assessment, and instruction(s) for			
	ongoing care, per day	which is one of our Clinical Payment and Coding Policy (CPCP).		
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	minutes of personal one-on-one contact with the patient	Plan. Not subject to pre-service review.		
97811	Acupuncture, 1 or more needles; without electrical stimulation, each	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	additional 15 minutes of personal one-on-one contact with the patient,	Plan. Not subject to pre-service review.		
	with re-insertion of needle(s) (List separately in addition to code for			
07040	primary procedure)		4.44.0000	10/01/0000
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
07044	minutes of personal one-on-one contact with the patient	Plan. Not subject to pre-service review.	4/4/0005	40/04/0000
97814	Acupuncture, 1 or more needles; with electrical stimulation, each	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	additional 15 minutes of personal one-on-one contact with the patient,	Plan. Not subject to pre-service review.		
	with re-insertion of needle(s) (List separately in addition to code for primary procedure)			
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy	MP Criteria: Procedure/service reviewed against	9/1/2023	2/29/2024
30370	response); device(s) supply with scheduled (eq. daily) recording(s) and/or	-	5/ 1/2025	2/23/2024
	programmed alert(s) transmission to monitor cognitive behavioral therapy,			
	each 30 davs			
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
99071	Educational supplies, such as books, tapes, and pamphlets, for the	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	patient's education at cost to physician or other qualified health care	Plan. Not subject to pre-service review.		
	professional			
99075	Medical testimony	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000		Plan. Not subject to pre-service review.	4/4/4050	10/01/0000
99080	Special reports such as insurance forms, more than the information	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	conveyed in the usual medical communications or standard reporting form	Plan. Not subject to pre-service review.		
99082	Unusual travel (eg, transportation and escort of patient)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
99175	Ipecac or similar administration for individual emesis and continued	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	observation until stomach adequately emptied of poison	Plan. Not subject to pre-service review.		
99360	Standby service, requiring prolonged attendance, each 30 minutes (eg,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	operative standby, standby for frozen section, for cesarean/high risk	Plan. Not subject to pre-service review.		
	delivery, for monitoring EEG)			
99450	Basic life and/or disability examination that includes: Measurement of	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	height, weight, and blood pressure; Completion of a medical history	Plan. Not subject to pre-service review.		
	following a life insurance pro forma; Collection of blood sample and/or			
	urinalysis complying with chain of custody protocols; and Completion of			
	necessary documentation/certificates.			

99455	Work related or medical disability examination by the treating physician	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with	Plan. Not subject to pre-service review.		
	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			
00450	documentation/certificates and report.	New Oscierca di Diversi di ma fa su di su stato screta di la stato	4/4/4050	40/04/0000
99456	Work related or medical disability examination by other than the treating	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination	Plan. Not subject to pre-service review.		
	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 personal care	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2018	12/31/2999
	lipoproteins, including all five major lipoprotein classes and subclasses of	Not subject to pre-service review. Check EIU policy,		
	HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2018	12/31/2999
	lipoproteins, including all five major lipoprotein classes and subclasses of	Not subject to pre-service review. Check EIU policy,		
	HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	which is one of our Clinical Payment and Coding		
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
00541	procedure, with image-guidance based on fluoroscopic images (List	Not subject to pre-service review. Check EIU policy,	9/1/2020	12/31/2999
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
	separately in addition to code for primary procedure	Policy (CPCP).		
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	procedure, with image-guidance based on fluoroscopic images (List	Not subject to pre-service review. Check EIU policy,		
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	procedure, with image-guidance based on CT/MRI images (List	Not subject to pre-service review. Check EIU policy,		
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
0055 T		Policy (CPCP).	0/1/0000	10/01/0000
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding		
	separately in addition to code for primary procedure)			
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
00020	biomarkers, utilizing serum, algorithm reported with a risk score	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/51/2999
	somarkere, amzing sorarr, agentinn reported with a hok source	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	biomarkers, utilizing serum, algorithm reported with a risk score	Not subject to pre-service review. Check EIU policy,		
	,,	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

by LC-MS/MS, using plasma, algorithm associated with autism spectrum disorder	EIU: Procedure/service not reimbursed by the Plan.	12/1/2)20 12/31/2999
associated with autism spectrum disorder			
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
by I.C-MS/MS using plasma algorithm		12/1/2020	12/31/2999
		12, 172020	12/01/2000
	, , , , , , , , , , , , , , , , , , , ,		
uterine leiomvomata, including MR		12/1/2023	12/31/2999
	Clinical Review to avoid post-service review.		
uterine leiomyomata, including MR	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
ume greater or equal to 200 cc of tissue	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
acranial vertebral artery stent(s), including	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
pretation, open or percutaneous; initial	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
acranial vertebral artery stent(s), including	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
pretation, open or percutaneous; each	Medical Policy Criteria. Submit for Recommended		
y in addition to code for primary	Clinical Review to avoid post-service review.		
		12/1/2)20 12/31/2999
ntraocular retinal electrode array, with			
		12/1/2020	9/14/2024
ntraocular retinal electrode array, with			
	Policy (CPCP).	0///0	10/04/0000
iving musculoskeletal system, not		9/1/2)20 12/31/2999
lying musculaskalatal system, not		0/1/2020	12/31/2999
iving musculoskeletal system, not		9/1/2020	12/31/2999
ormed by a physician requiring		9/1/2	12/31/2999
		5/1/2	12/31/2999
ormed by a physician requiring		9/1/2020	12/31/2999
		0, 1/2020	12/01/2000
	Policy (CPCP).		
	uterine leiomyomata, including MR lume less than 200 cc of tissue uterine leiomyomata, including MR lume greater or equal to 200 cc of tissue racranial vertebral artery stent(s), including pretation, open or percutaneous; initial	associated with autism spectrum disorder associated with autism spectrum disorder which is one of our Clinical Payment and Coding Policy (CPCP).uterine leiomyomata, including MR lume less than 200 cc of tissueMP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.uterine leiomyomata, including MR lume greater or equal to 200 cc of tissueMP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.acranial vertebral artery stent(s), including pretation, open or percutaneous; initial pretation, open or percutaneous; each ly in addition to code for primaryMP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.retinal prosthesis receiver and pulse ntraocular retinal electrode array, withEIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).olving musculoskeletal system, notEIU: Procedure/service not reimbursed by the Plan. 	associated with autism spectrum disorder Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). 12/1/2023 uterine leiomyomata, including MR lume 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 uterine leiomyomata, including MR lume 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. 11/15/2006 racranial vertebral artery stent(s), including MP Criteria: Procedure/service reviewed against metatory stent(s), including MP Criteria: Procedure/service reviewed against MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. 11/15/2006 retranal vertebral artery stent(s), including MP Criteria: Procedure/service rotiewed against to subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). 11/15/2006 retinal prosthesis receiver and pulse Intraocular retinal electrode array, with microacular retinal electrode array, with Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). 12/1/2020 ving musculoskeletal system, not EIU: Procedure/service not reimbursed by 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

0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent	MP Criteria: Procedure/service reviewed against	10/1/2024	12/31/2999
	immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor	Medical Policy Criteria. Submit for Recommended		
	superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1)	Clinical Review to avoid post-service review.		
	combined with longitudinal clinical data, including APOL1 genotype if			
	available, and plasma (isolated fresh or frozen), algorithm reported as			
	probability score for rapid kidney function decline (RKFD)			
0106T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	20 12/31/2999
	extremity; using touch pressure stimuli to assess large diameter	Not subject to pre-service review. Check EIU policy,		
	sensation	which is one of our Clinical Payment and Coding		
04007	Overtitative concernations (OCT) testion and intermediation new	Policy (CPCP).	0/4/2020	40/04/0000
0106T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	extremity; using touch pressure stimuli to assess large diameter	Not subject to pre-service review. Check EIU policy,		
	sensation	which is one of our Clinical Payment and Coding		
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/202	20 12/31/2999
01000	radioisotope carbon-13 (13C) spirulina substrate, analysis of each	Not subject to pre-service review. Check EIU policy,	12/1/202	12/31/2999
	specimen by gas isotope ratio mass spectrometry, reported as rate of	which is one of our Clinical Payment and Coding		
	13CO2 excretion	Policy (CPCP).		
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	radioisotope carbon-13 (13C) spirulina substrate, analysis of each	Not subject to pre-service review. Check EIU policy,	, .,_0_0	,
	specimen by gas isotope ratio mass spectrometry, reported as rate of	which is one of our Clinical Payment and Coding		
	13CO2 excretion	Policy (CPCP).		
0107T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	20 12/31/2999
	extremity; using vibration stimuli to assess large diameter fiber sensation	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0107T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	extremity; using vibration stimuli to assess large diameter fiber sensation	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0108T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	20 12/31/2999
	extremity; using cooling stimuli to assess small nerve fiber sensation and	Not subject to pre-service review. Check EIU policy,		
	hyperalgesia	which is one of our Clinical Payment and Coding		
0108T	Quantitative concern testing (QCT) testing and interpretation per	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
01001	Quantitative sensory testing (QST), testing and interpretation per		9/1/2020	12/31/2999
	extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding		
	nyperaigesia	Policy (CPCP).		
0109T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	20 12/31/2999
01001	extremity; using heat-pain stimuli to assess small nerve fiber sensation	Not subject to pre-service review. Check EIU policy,	0/1/202	12/01/2000
	and hyperalgesia	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0109T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	extremity; using heat-pain stimuli to assess small nerve fiber sensation	Not subject to pre-service review. Check EIU policy,		
	and hyperalgesia	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0110T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	20 12/31/2999
	extremity; using other stimuli to assess sensation	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

0110T	Quantitative sensory testing (QST), testing and interpretation per	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	extremity; using other stimuli to assess sensation	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
0198T	Measurement of ocular blood flow by repetitive intraocular pressure	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
01301	sampling, with interpretation and report	Not subject to pre-service review. Check EIU policy,		12/1/2020	12/51/2999
	sampling, with interpretation and report	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0198T	Measurement of ocular blood flow by repetitive intraocular pressure	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	sampling, with interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding Policy (CPCP).			
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s),	MP Criteria: Procedure/service reviewed against	11/1/2019		12/31/2999
	including the use of a balloon or mechanical device, when used, 1 or	Medical Policy Criteria. Submit for Recommended			
	more needles, includes imaging guidance and bone biopsy, when performed	Clinical Review to avoid post-service review.			
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections,	MP Criteria: Procedure/service reviewed against	11/1/2019		12/31/2999
	including the use of a balloon or mechanical device, when used, 2 or	Medical Policy Criteria. Submit for Recommended			
	more needles, includes imaging guidance and bone biopsy, when performed	Clinical Review to avoid post-service review.			
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement),	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	fixation, injection of bone cement, when performed, including fluoroscopy,	which is one of our Clinical Payment and Coding			
	single level, lumbar spine	Policy (CPCP).			
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement),	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	including facetectomy, laminectomy, foraminotomy, and vertebral column	Not subject to pre-service review. Check EIU policy,			
	fixation, injection of bone cement, when performed, including fluoroscopy,	which is one of our Clinical Payment and Coding			
	single level, lumbar spine	Policy (CPCP).			
0207T	Evacuation of meibomian glands, automated, using heat and intermittent	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	pressure, unilateral	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0207T	Evacuation of meibomian glands, automated, using heat and intermittent	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	pressure, unilateral	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; cervical	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; cervical	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; thoracic	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; thoracic	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; lumbar	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; lumbar	which is one of our Clinical Payment and Coding			
0000 		Policy (CPCP).		40/4/0000	40/04/0000
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
1					
0000 T	to code for primary procedure)	Policy (CPCP).	40/4/0000		40/04/0000
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	including imaging and placement of bone graft(s) or synthetic device(s),	Not subject to pre-service review. Check EIU policy,			
	single level; each additional vertebral segment (List separately in addition				
000411	to code for primary procedure)	Policy (CPCP).		0/4/0000	40/04/0000
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan.		6/1/2023	12/31/2999
	2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding Policy (CPCP).			
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023		12/31/2999
02240	2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	Not subject to pre-service review. Check EIU policy,	0/ 1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory	EIU: Procedure/service not reimbursed by the Plan.	1	6/1/2023	12/31/2999
	syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-	Not subject to pre-service review. Check EIU policy,			
	19]), ELISA, plasma, seru	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023		12/31/2999
	syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-	Not subject to pre-service review. Check EIU policy,			
	19]), ELISA, plasma, seru	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0232T	Injection(s), platelet rich plasma, any site, including image guidance,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	harvesting and preparation when performed	Not subject to pre-service 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 guidance,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	harvesting and preparation when performed	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0253T	Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed against	1/1/2011		12/31/2999
	extraocular reservoir, internal approach, into the suprachoroidal space	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

0263T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,	5/ 1/20	12/31/2999
	guidance, if performed; complete procedure including unlateral or	which is one of our Clinical Payment and Coding		
	bilateral bone marrow harvest	Policy (CPCP).		
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, if performed; complete procedure including unilateral or	which is one of our Clinical Payment and Coding		
	bilateral bone marrow harvest	Policy (CPCP).		
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, if performed; complete procedure excluding bone marrow	which is one of our Clinical Payment and Coding		
	harvest	Policy (CPCP).		
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, if performed; complete procedure excluding bone marrow	which is one of our Clinical Payment and Coding		
	harvest	Policy (CPCP).		
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/20	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, if performed; unilateral or bilateral bone marrow harvest only for	which is one of our Clinical Payment and Coding		
	intramuscular autologous bone marrow cell therapy	Policy (CPCP).		
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, if performed; unilateral or bilateral bone marrow harvest only for	which is one of our Clinical Payment and Coding		
	intramuscular autologous bone marrow cell therapy	Policy (CPCP).		
0266T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	total system (includes generator placement, unilateral or bilateral lead	Medical Policy Criteria. Submit for Recommended		
	placement, intra-operative interrogation, programming, and repositioning,	Clinical Review to avoid post-service review.		
	when performed)			
0267T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	lead only, unilateral (includes intra-operative interrogation, programming,	Medical Policy Criteria. Submit for Recommended		
	and repositioning, when performed)	Clinical Review to avoid post-service review.		
0268T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	pulse generator only (includes intra-operative interrogation, programming,	Medical Policy Criteria. Submit for Recommended		
	and repositioning, when performed)	Clinical Review to avoid post-service review.		
0269T	Revision or removal of carotid sinus baroreflex activation device; total	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	system (includes generator placement, unilateral or bilateral lead	Medical Policy Criteria. Submit for Recommended		
	placement, intra-operative interrogation, programming, and repositioning,	Clinical Review to avoid post-service review.		
	when performed)			
0270T	Revision or removal of carotid sinus baroreflex activation device; lead	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	only, unilateral (includes intra-operative interrogation, programming, and	Medical Policy Criteria. Submit for Recommended		
	repositioning, when performed)	Clinical Review to avoid post-service review.		
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	generator only (includes intra-operative interrogation, programming, and	Medical Policy Criteria. Submit for Recommended		
	repositioning, when performed)	Clinical Review to avoid post-service review.	0// 0/00//0	10/01/0000
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	activation system, including telemetric iterative communication with the	Medical Policy Criteria. Submit for Recommended		
	implantable device to monitor device diagnostics and programmed	Clinical Review to avoid post-service review.		
	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);			

0273T	Interrogation device evaluation (in person), carotid sinus baroreflex	MP Criteria: Procedure/service reviewed against	10/1/2022		12/31/2999
	activation system, including telemetric iterative communication with the	Medical Policy Criteria. Submit for Recommended			
	implantable device to monitor device diagnostics and programmed	Clinical Review to avoid post-service review.			
	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				
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	decompression of neural elements, (with or without ligamentous	Not subject to pre-service review. Check EIU policy,			
	resection, discectomy, facetectomy and/or foraminotomy), any method,	which is one of our Clinical Payment and Coding			
	under indirect image guidance (eg, fluoroscopic, CT), single or multiple	Policy (CPCP).			
007.17	levels, unilateral or bilateral; cervical or thoracic				10/01/0000
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	decompression of neural elements, (with or without ligamentous	Not subject to pre-service review. Check EIU policy,			
	resection, discectomy, facetectomy and/or foraminotomy), any method,	which is one of our Clinical Payment and Coding			
	under indirect image guidance (eg, fluoroscopic, CT), single or multiple	Policy (CPCP).			
0275T	levels, unilateral or bilateral; cervical or thoracic Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
02751	decompression of neural elements, (with or without ligamentous	Not subject to pre-service review. Check EIU policy,		1/1/2023	12/31/2999
	resection, discectomy, facetectomy and/or foraminotomy), any method,	which is one of our Clinical Payment and Coding			
	under indirect image guidance (eg, fluoroscopic, CT), single or multiple	Policy (CPCP).			
	levels, unilateral or bilateral; lumbar				
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
02.01	decompression of neural elements, (with or without ligamentous	Not subject to pre-service review. Check EIU policy,			12/01/2000
	resection, discectomy, facetectomy and/or foraminotomy), any method,	which is one of our Clinical Payment and Coding			
	under indirect image guidance (eg, fluoroscopic, CT), single or multiple	Policy (CPCP).			
	levels, unilateral or bilateral; lumbar				
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	therapy), each treatment session (includes placement of electrodes)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	therapy), each treatment session (includes placement of electrodes)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0308T	Incortion of coulor tolocoope proothesis including removal of crystelling	Policy (CPCP). MP Criteria: Procedure/service reviewed against	7/1/2012		12/31/2999
03001	Insertion of ocular telescope prosthesis including removal of crystalline	Medical Policy Criteria. Submit for Recommended	// 1/2012		12/31/2999
	lens or intraocular lens prosthesis	-			
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements	Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan.		1/15/2024	12/31/2999
03220	of 14 acyl carnitines and microbiome-derived metabolites, liquid	Not subject to pre-service review. Check EIU policy,		1/13/2024	12/31/2999
	chromatography with tandem mass spectrometry (LC-MS/MS), plasma,	which is one of our Clinical Payment and Coding			
	results reported as negative or positive for risk of metabolic subtypes	Policy (CPCP).			
	associated with ASD				
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements	EIU: Procedure/service not reimbursed by the Plan.	1/15/2024		12/31/2999
	of 14 acyl carnitines and microbiome-derived metabolites, liquid	Not subject to pre-service review. Check EIU policy,			
	chromatography with tandem mass spectrometry (LC-MS/MS), plasma,	which is one of our Clinical Payment and Coding			
	results reported as negative or positive for risk of metabolic subtypes	Policy (CPCP).			
	associated with ASD				

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

0339T	Transcatheter renal sympathetic denervation, percutaneous approach	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	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	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/202	12/31/2999
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/202	12/31/2999
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/202	12/31/2999
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/202	12/31/2999
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999

0358T	Bioelectrical impedance analysis whole body composition assessment,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	with interpretation and report	Not subject to pre-service review. Check EIU policy,		12/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0358T	Bioelectrical impedance analysis whole body composition assessment,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	with interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0369U	Infectious agent detection by nucleic acid (DNA and RNA),	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms	Not subject to pre-service review. Check EIU policy,			
	and identification of 21 associated antibiotic-resistance genes, multiplex	which is one of our Clinical Payment and Coding			
	amplified probe technique	Policy (CPCP).			
0369U	Infectious agent detection by nucleic acid (DNA and RNA),	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms	Not subject to pre-service review. Check EIU policy,			
	and identification of 21 associated antibiotic-resistance genes, multiplex	which is one of our Clinical Payment and Coding			
	amplified probe technique	Policy (CPCP).			
0369U	Infectious agent detection by nucleic acid (DNA and RNA),	MP Criteria: Procedure/service reviewed against	2/1/2024		5/14/2024
	gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms	Medical Policy Criteria. Submit for Recommended			
	and identification of 21 associated antibiotic-resistance genes, multiplex	Clinical Review to avoid post-service review.			
	amplified probe technique				
0378T	Visual field assessment, with concurrent real time data analysis and	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	accessible data storage with patient initiated data transmitted to a remote				
	surveillance center for up to 30 days; review and interpretation with report				
0070 7	by a physician or other qualified health care professional	Policy (CPCP).	10/1/0000		1010110000
0378T	Visual field assessment, with concurrent real time data analysis and	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	accessible data storage with patient initiated data transmitted to a remote				
	surveillance center for up to 30 days; review and interpretation with report				
00 7 0 7	by a physician or other qualified health care professional	Policy (CPCP).		40/4/0000	10/01/0000
0379T	Visual field assessment, with concurrent real time data analysis and	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	accessible data storage with patient initiated data transmitted to a remote	Not subject to pre-service review. Check EIU policy,			
	surveillance center for up to 30 days; technical support and patient	which is one of our Clinical Payment and Coding			
	instructions, surveillance, analysis, and transmission of daily and	Policy (CPCP).			
	emergent data reports as prescribed by a physician or other qualified				
0379T	health care professional	Filly Dragodurg/garvieg not reimburged by the Dian	12/1/2020		12/31/2999
03791	Visual field assessment, with concurrent real time data analysis and	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	accessible data storage with patient initiated data transmitted to a remote	Not subject to pre-service review. Check EIU policy,			
	surveillance center for up to 30 days; technical support and patient	which is one of our Clinical Payment and Coding			
	instructions, surveillance, analysis, and transmission of daily and	Policy (CPCP).			
	emergent data reports as prescribed by a physician or other qualified				
0397T	health care professional Endoscopic retrograde cholangiopancreatography (ERCP), with optical	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
03971	endomicroscopy (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,		9/1/2020	12/31/2999
		which is one of our Clinical Payment and Coding			
	procedure)				
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
009/1	endomicroscopy (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,	3/1/2020		12/31/2999
	procedure)	which is one of our Clinical Payment and Coding			
	procedure)				
		Policy (CPCP).			

0398T	Magnetic resonance image guided high intensity focused ultrasound	MP Criteria: Procedure/service reviewed against	3/1/2020	12/31/2999
1	(MRgFUS), stereotactic ablation lesion, intracranial for movement	Medical Policy Criteria. Submit for Recommended		
	disorder including stereotactic navigation and frame placement when performed	Clinical Review to avoid post-service review.		
)402T	Collagen cross-linking of cornea, including removal of the corneal	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
	epithelium, when performed, and intraoperative pachymetry, when	Medical Policy Criteria. Submit for Recommended		
	performed	Clinical Review to avoid post-service review.		
0407U	Nephrology (diabetic chronic kidney disease [CKD]), multiplex	MP Criteria: Procedure/service reviewed against	10/1/2024	12/31/2999
	electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis			
	factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2),	Clinical Review to avoid post-service review.		
	and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma,			
	algorithm reported as risk for progressive decline in kidney function			
)408T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended		
	programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	Clinical Review to avoid post-service review.		
0409T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended		
	programming of sensing and therapeutic parameters; pulse generator	Clinical Review to avoid post-service review.		
	only		0// = /000 /	10/01/0000
0410T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended		
	programming of sensing and therapeutic parameters; atrial electrode only	Clinical Review to avoid post-service review.		
0411T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended		
	programming of sensing and therapeutic parameters; ventricular electrode	Clinical Review to avoid post-service review.		
0440T	only	MD Oritoria December (comic considered a scient	0/45/0004	40/04/0000
0412T	Removal of permanent cardiac contractility modulation system; pulse	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	generator only	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
0413T	Removal of permanent cardiac contractility modulation system;	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	transvenous electrode (atrial or ventricular)	Medical Policy Criteria. Submit for Recommended	0,10,2021	12/01/2000
		Clinical Review to avoid post-service review.		
)414T	Removal and replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system pulse generator only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)415T	Repositioning of previously implanted cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	transvenous electrode (atrial or ventricular lead)	Medical Policy Criteria. Submit for Recommended		
0416T	Relocation of skin pocket for implanted cardiac contractility modulation	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
04101	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	Medical Policy Criteria. Submit for Recommended	3/15/2024	12/31/2999
	puise generator	Clinical Review to avoid post-service review.		
0417T	Programming device evaluation (in person) with iterative adjustment of	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	the implantable device to test the function of the device and select optimal		5, 10, 202 1	12.0.12000
		Clinical Review to avoid post-service review.		
	implantable cardiac contractility modulation system			

0418T	Interrogation device evaluation (in person) with analysis, review and	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	report, includes connection, recording and disconnection per patient	Medical Policy Criteria. Submit for Recommended	0, 10,2021	,
	encounter, implantable cardiac contractility modulation system	Clinical Review to avoid post-service review.		
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	bilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	extremity distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	extremity distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended		
	······································	Clinical Review to avoid post-service review.		
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0449T	Insertion of aqueous drainage device, without extraocular reservoir,	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	internal approach, into the subconjunctival space; initial device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0450T	Insertion of aqueous drainage device, without extraocular reservoir,	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	internal approach, into the subconjunctival space; each additional device	Medical Policy Criteria. Submit for Recommended		
	(List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
0464T	Visual evoked potential, testing for glaucoma, with interpretation and	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	report	Not subject to pre-service 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	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	report	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0472T	Device evaluation, interrogation, and initial programming of intraocular	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	retinal electrode array (eg, retinal prosthesis), in person, with iterative	Not subject to pre-service review. Check EIU policy,		
	adjustment of the implantable device to test functionality, select optimal	which is one of our Clinical Payment and Coding		
	permanent programmed values with analysis, including visual training,	Policy (CPCP).		
	with review and report by a qualified health care professional			
0472T	Device evaluation, interrogation, and initial programming of intraocular	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	9/14/2024
	retinal electrode array (eg, retinal prosthesis), in person, with iterative	Not subject to pre-service review. Check EIU policy,		
	adjustment of the implantable device to test functionality, select optimal	which is one of our Clinical Payment and Coding		
	permanent programmed values with analysis, including visual training,	Policy (CPCP).		
	with review and report by a qualified health care professional			
0473T	Device evaluation and interrogation of intraocular retinal electrode array	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	(eg, retinal prosthesis), in person, including reprogramming and visual	Not subject to pre-service review. Check EIU policy,		
	training, when performed, with review and report by a qualified health care			
	professional	Policy (CPCP).		
0473T	Device evaluation and interrogation of intraocular retinal electrode array	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	9/14/2024
	(eg, retinal prosthesis), in person, including reprogramming and visual	Not subject to pre-service review. Check EIU policy,		
	training, when performed, with review and report by a qualified health care			
	professional	Policy (CPCP).		
0474T	Insertion of anterior segment aqueous drainage device, with creation of	MP Criteria: Procedure/service reviewed against	7/1/2017	12/31/2999
	intraocular reservoir, internal approach, into the supraciliary space	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	11/1/2019	12/31/2999
0480T	surface area of infants and children Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	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.	11/1/2019	12/31/2999
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1	2/1/2020 12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1	2/1/2020 12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed: first two hours in sterile field	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	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	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	transilluminated light) of meibomian glands, unilateral or bilateral, with	Not subject to pre-service review. Check EIU policy,			
	interpretation and report	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0507T	Near infrared dual imaging (ie, simultaneous reflective and	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	transilluminated light) of meibomian glands, unilateral or bilateral, with	Not subject to pre-service review. Check EIU policy,			
	interpretation and report	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0512T	Extracorporeal shock wave for integumentary wound healing, including	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	topical application and dressing care; initial wound	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0512T	Extracorporeal shock wave for integumentary wound healing, including	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	topical application and dressing care; initial wound	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
05/07		Policy (CPCP).	-		10/01/0000
0513T	Extracorporeal shock wave for integumentary wound healing, including	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
	topical application and dressing care; each additional wound (List	Not subject to pre-service review. Check EIU policy,			
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
0540 7		Policy (CPCP).	0/4/0000		10/01/0000
0513T	Extracorporeal shock wave for integumentary wound healing, including	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
	topical application and dressing care; each additional wound (List	Not subject to pre-service review. Check EIU policy,			
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
05407	la suffere effectively a suffere stimulater for left contributer restriction in the left	Policy (CPCP).	40/4/0040		40/04/0000
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including		10/1/2019		12/31/2999
	device interrogation and programming, and imaging supervision and	Medical Policy Criteria. Submit for Recommended			
0517T	interpretation, when performed; electrode only	Clinical Review to avoid post-service review.	10/1/0040		12/21/2000
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including		10/1/2019		12/31/2999
	device interrogation and programming, and imaging supervision and	Medical Policy Criteria. Submit for Recommended			
	interpretation, when performed; both components of pulse generator	Clinical Review to avoid post-service review.			
	(battery and transmitter) only				

0524T	Endovenous catheter directed chemical ablation with balloon isolation of	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
03241	incompetent extremity vein, open or percutaneous, including all vascular	Medical Policy Criteria. Submit for Recommended	10/1/2019	12/31/2999
	access, catheter manipulation, diagnostic imaging, imaging guidance and			
	monitoring			
0529T	Interrogation device evaluation (in person) of intracardiac ischemia	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
	monitoring system with analysis, review, and report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	derived T lymphocytes for development of genetically modified autologous	Medical Policy Criteria. Submit for Recommended		
	CAR-T cells, per day	Clinical Review to avoid post-service review.		
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	derived T lymphocytes for transportation (eg, cryopreservation, storage)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation		6/15/2023	12/31/2999
	of CAR-T cells for administration	Medical Policy Criteria. Submit for Recommended		
0.5. (0. 		Clinical Review to avoid post-service review.	0/15/0000	10/01/0000
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	administration, autologous	Medical Policy Criteria. Submit for Recommended		
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
05441		•	10/1/2022	12/31/2999
	adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
00401	adjustable annulus reconstruction device, percutaneous approach	Medical Policy Criteria. Submit for Recommended	5/1/2025	12/31/2999
		Clinical Review to avoid post-service review.		
0546T	Radiofrequency spectroscopy, real time, intraoperative margin	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	assessment, at the time of partial mastectomy, with report	Medical Policy Criteria. Submit for Recommended	., .,	,
	······································	Clinical Review to avoid post-service review.		
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic	MP Criteria: Procedure/service reviewed against	12/15/2020	12/31/2999
	energies, provided by a physician or other qualified health care	Medical Policy Criteria. Submit for Recommended		
	professional	Clinical Review to avoid post-service review.		
0563T	Evacuation of meibomian glands, using heat delivered through wearable,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	open-eye eyelid treatment devices and manual gland expression, bilateral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0563T	Evacuation of meibomian glands, using heat delivered through wearable,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	open-eye eyelid treatment devices and manual gland expression, bilateral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
0505 T		Policy (CPCP).	0/15/000/	10/01/0000
0565T	Autologous cellular implant derived from adipose tissue for the treatment	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	of osteoarthritis of the knees; tissue harvesting and cellular implant	Not subject to pre-service review. Check EIU policy,		
	creation	which is one of our Clinical Payment and Coding		
0505 T	A state was a still be involved device of former a finance for the formation of	Policy (CPCP).	0/45/0004	40/04/0000
0565T	Autologous cellular implant derived from adipose tissue for the treatment	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	of osteoarthritis of the knees; tissue harvesting and cellular implant	Not subject to pre-service review. Check EIU policy,		
	creation	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

0566T	Autologous cellular implant derived from adipose tissue for the treatment	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)		10/1/2024	12/31/2999

0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence,	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
	location, and load, per session; first anatomic site (eg, lower extremity)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence,	MP Criteria: Procedure/service reviewed against	8/15/2024		9/30/2024
	location, and load, per session; first anatomic site (eg, lower extremity)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence,	EIU: Procedure/service not reimbursed by the Plan.		10/1/2024	12/31/2999
	location, and load, per session; each additional anatomic site (eg, upper	Not subject to pre-service review. Check EIU policy,			
	extremity) (List separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence,		10/1/2024		12/31/2999
	location, and load, per session; each additional anatomic site (eg, upper	Not subject to pre-service review. Check EIU policy,			
	extremity) (List separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence,	5	8/15/2024		9/30/2024
	location, and load, per session; each additional anatomic site (eg, upper	Medical Policy Criteria. Submit for Recommended			
	extremity) (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.			
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ,	MP Criteria: Procedure/service reviewed against	9/1/2023		12/31/2999
	including imaging guidance, when performed, percutaneous	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ,	MP Criteria: Procedure/service reviewed against	9/1/2023		12/31/2999
	including fluoroscopic and ultrasound guidance, when performed, open	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including	EIU: Procedure/service not reimbursed by the Plan.		4/1/2021	12/31/2999
	sensor placement and administration of a single dose of fluorescent	Not subject to pre-service review. Check EIU policy,			
	pyrazine agent	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including	EIU: Procedure/service not reimbursed by the Plan.	4/1/2021		12/31/2999
	sensor placement and administration of a single dose of fluorescent	Not subject to pre-service review. Check EIU policy,			
	pyrazine agent	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor	EIU: Procedure/service not reimbursed by the Plan.		4/1/2021	12/31/2999
	placement and administration of more than one dose of fluorescent	Not subject to pre-service review. Check EIU policy,			
	pyrazine agent, each 24 hours	which is one of our Clinical Payment and Coding			
0603T	Clemenuler filtration rate (CED) menitering transferred industry	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	4/1/2021		12/31/2999
00031	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor		4/1/2021		12/31/2999
	placement and administration of more than one dose of fluorescent	Not subject to pre-service review. Check EIU policy,			
	pyrazine agent, each 24 hours	which is one of our Clinical Payment and Coding			
0615T	Eye-movement analysis without spatial calibration, with interpretation and	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
00131	report	Not subject to pre-service review. Check EIU policy,		5/15/2021	12/31/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0615T	Eye-movement analysis without spatial calibration, with interpretation and		5/15/2021		12/31/2999
00101	report	Not subject to pre-service review. Check EIU policy,	0,10,2021		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy	EIU: Procedure/service not reimbursed by the Plan.	7/1/2	12/31/2999
00191	and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	11112	.024 12/31/2335
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2	2021 12/31/2999
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2	2021 12/31/2999
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2	2021 12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2	2021 12/31/2999

0623T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021		12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,			
	computed tomographic angiography; data preparation and transmission,	which is one of our Clinical Payment and Coding			
	computerized analysis of data, with review of computerized analysis	Policy (CPCP).			
	output to reconcile discordant data, interpretation and report				
0624T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.		1/1/2021	12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,			
	computed tomographic angiography; data preparation and transmission	which is one of our Clinical Payment and Coding			
000 / T		Policy (CPCP).	4/4/0004		40/04/0000
0624T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021		12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,			
	computed tomographic angiography; data preparation and transmission	which is one of our Clinical Payment and Coding			
0625T	Automated guantification and observatorization of correspondentia	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		1/1/2021	12/31/2999
00231	Automated quantification and characterization of coronary atherosclerotic plague to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		1/1/2021	12/31/2999
	computed tomographic angiography; computerized analysis of data from	· · · · · · · · · · · · · · · · · · ·			
	computed tomographic angiography, computenzed analysis of data from coronary computed tomographic angiography	which is one of our Clinical Payment and Coding Policy (CPCP).			
0625T	Automated quantification and characterization of coronary atherosclerotic		1/1/2021		12/31/2999
00231	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,	1/ 1/2021		12/31/2999
	computed tomographic angiography; computerized analysis of data from	which is one of our Clinical Payment and Coding			
	coronary computed tomographic angiography	Policy (CPCP).			
0626T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.		1/1/2021	12/31/2999
00201	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		., ., _ 0 _ 1	12/01/2000
	computed tomographic angiography; review of computerized analysis	which is one of our Clinical Payment and Coding			
	output to reconcile discordant data, interpretation and report	Policy (CPCP).			
0626T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021		12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,			
	computed tomographic angiography; review of computerized analysis	which is one of our Clinical Payment and Coding			
	output to reconcile discordant data, interpretation and report	Policy (CPCP).			
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.		1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,			
	guidance, lumbar; first level	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product,		1/1/2021		12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,			
	guidance, lumbar; first level	which is one of our Clinical Payment and Coding			
~~~~		Policy (CPCP).	-		10/01/0000
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product,			1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,			
	guidance, lumbar; each additional level (List separately in addition to code	, , , , , , , , , , , , , , , , , , , ,			
06007	for primary procedure)	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	1/1/2024		12/21/2000
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product,		1/1/2021		12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,			
	guidance, lumbar; each additional level (List separately in addition to code				
	for primary procedure)	Policy (CPCP).			

0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/202	12/31/2999
00201	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,	17 17 202	12/01/2000
	lumbar: first level	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,		
	lumbar; first level	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/202	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,		
	lumbar; each additional level (List separately in addition to code for	which is one of our Clinical Payment and Coding		
	primary procedure)	Policy (CPCP).		
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product,		1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,		
	lumbar; each additional level (List separately in addition to code for	which is one of our Clinical Payment and Coding		
000 / <del>T</del>	primary procedure)	Policy (CPCP).	414/000	40/04/0000
0631T	Transcutaneous visible light hyperspectral imaging measurement of	EIU: Procedure/service not reimbursed by the Plan.	1/1/202	12/31/2999
	oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with	Not subject to pre-service review. Check EIU policy,		
	interpretation and report, per extremity	which is one of our Clinical Payment and Coding		
0631T	Transcutaneous visible light hyperspectral imaging measurement of	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
00311	oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with	Not subject to pre-service review. Check EIU policy,	1/ 1/2021	12/31/2999
	interpretation and report, per extremity	which is one of our Clinical Payment and Coding		
	interpretation and report, per extremity	Policy (CPCP).		
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00021	pulmonary arteries, including right heart catheterization, pulmonary artery			12/01/2000
	angiography, and all imaging guidance	Clinical Review to avoid post-service review.		
0639T	Wireless skin sensor thermal anisotropy measurement(s) and	EIU: Procedure/service not reimbursed by the Plan.	1/1/202	12/31/2999
	assessment of flow in cerebrospinal fluid shunt, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0639T	Wireless skin sensor thermal anisotropy measurement(s) and	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	assessment of flow in cerebrospinal fluid shunt, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of	EIU: Procedure/service not reimbursed by the Plan.	7/1/202	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other			
	than for screening for peripheral arterial disease, image acquisition,	which is one of our Clinical Payment and Coding		
	interpretation, and report; first anatomic site	Policy (CPCP).		
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other			
	than for screening for peripheral arterial disease, image acquisition,	which is one of our Clinical Payment and Coding		
00407	interpretation, and report; first anatomic site	Policy (CPCP).	7/4/0004	40/04/0000
0643T	Transcatheter left ventricular restoration device implantation including	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	right and left heart catheterization and left ventriculography when	Medical Policy Criteria. Submit for Recommended		
0645T	performed, arterial approach Transcatheter implantation of coronary sinus reduction device including	Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
00401		MP Criteria: Procedure/service reviewed against	1/1/2021	12/31/2999
	vascular access and closure, right heart catheterization, venous	Medical Policy Criteria. Submit for Recommended		
	angiography, coronary sinus angiography, imaging guidance, and	Clinical Review to avoid post-service review.		
	supervision and interpretation, when performed			

0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with	MP Criteria: Procedure/service reviewed against	7/1/2021		12/31/2999
	prosthetic valve, percutaneous approach, including right heart	Medical Policy Criteria. Submit for Recommended			
	catheterization, temporary pacemaker insertion, and selective right	Clinical Review to avoid post-service review.			
	ventricular or right atrial angiography, when performed				
0650T		MP Criteria: Procedure/service reviewed against	7/1/2021		12/31/2999
	monitor system, with iterative adjustment of the implantable device to test	Medical Policy Criteria. Submit for Recommended			
	the function of the device and select optimal permanently programmed	Clinical Review to avoid post-service review.			
	values with analysis, review and report by a physician or other qualified				
	health care professional				
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach,	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
	including intraprocedural positioning of capsule, with interpretation and	Not subject to pre-service review. Check EIU policy,			
	report	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
	including intraprocedural positioning of capsule, with interpretation and	Not subject to pre-service review. Check EIU policy,			
	report	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7	EIU: Procedure/service not reimbursed by the Plan.		7/1/2021	12/31/2999
	vertebral segments	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
OGEGT	Anterior lumber or theree clumber vertebred hed visithering up to 7	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	7/1/2021		12/21/2000
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7	-	7/1/2021		12/31/2999
	vertebral segments	Not subject to pre-service 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 more	EIU: Procedure/service not reimbursed by the Plan.		7/1/2021	12/31/2999
00071	vertebral segments	Not subject to pre-service review. Check EIU policy,		11112021	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021		12/31/2999
	vertebral segments	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0664T	Donor hysterectomy (including cold preservation); open, from cadaver	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	donor	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0664T	Donor hysterectomy (including cold preservation); open, from cadaver	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	donor	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
000FT		Policy (CPCP).		0/45/0004	40/04/0000
0665T	Donor hysterectomy (including cold preservation); open, from living donor	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
06657	Depart hystorestemy (including cold preservation), onen from living depart	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
0665T	Donor hysterectomy (including cold preservation); open, from living donor		0/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic,	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	from living donor	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic,	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	from living donor	Not subject to pre-service review. Check EIU policy,			
	······································	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0667T	Donor hysterectomy (including cold preservation); recipient uterus	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	allograft transplantation from cadaver or living donor	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0667T	Donor hysterectomy (including cold preservation); recipient uterus	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	allograft transplantation from cadaver or living donor	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0668T	Backbench standard preparation of cadaver or living donor uterine	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	allograft prior to transplantation, including dissection and removal of	Not subject to pre-service review. Check EIU policy,			
	surrounding soft tissues and preparation of uterine vein(s) and uterine	which is one of our Clinical Payment and Coding			
	artery(ies), as necessary	Policy (CPCP).			
0668T	Backbench standard preparation of cadaver or living donor uterine	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	allograft prior to transplantation, including dissection and removal of	Not subject to pre-service review. Check EIU policy,			
	surrounding soft tissues and preparation of uterine vein(s) and uterine	which is one of our Clinical Payment and Coding			
	artery(ies), as necessary	Policy (CPCP).			
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	to transplantation; venous anastomosis, each	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	to transplantation; venous anastomosis, each	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior	EIU: Procedure/service not reimbursed by the Plan.		8/15/2021	12/31/2999
	to transplantation; arterial anastomosis, each	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	to transplantation; arterial anastomosis, each	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the			1/1/2023	12/31/2999
	tissues surrounding the female bladder neck and proximal urethra for	Not subject to pre-service review. Check EIU policy,			
	urinary incontinence	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the		1/1/2023		12/31/2999
	tissues surrounding the female bladder neck and proximal urethra for	Not subject to pre-service review. Check EIU policy,			
	urinary incontinence	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

0692T	Therapeutic ultrafiltration	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without	MP Criteria: Procedure/service reviewed against	11/1/2024	12/31/2999
	implantation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0740T	Remote autonomous algorithm-based recommendation system for insulin		9/1/2023	12/31/2999
	dose calculation and titration; initial set-up and patient education	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0741T		MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	dose calculation and titration; provision of software, data collection,	Medical Policy Criteria. Submit for Recommended		
	transmission, and storage, each 30 days	Clinical Review to avoid post-service review.		
0743T	Bone strength and fracture risk using finite element analysis of functional	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	3 12/31/2999
	data and bone mineral density (BMD), with concurrent vertebral fracture	Not subject to pre-service review. Check EIU policy,		
	assessment, utilizing data from a computed tomography scan, retrieval	which is one of our Clinical Payment and Coding		
	and transmission of the scan data, measurement of bone strength and	Policy (CPCP).		
	BMD and classification of any vertebral fractures, with overall fracture-risk			
	assessment, interpretation and report			
0743T	Bone strength and fracture risk using finite element analysis of functional	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	data and bone mineral density (BMD), with concurrent vertebral fracture	Not subject to pre-service review. Check EIU policy,		
	assessment, utilizing data from a computed tomography scan, retrieval	which is one of our Clinical Payment and Coding		
	and transmission of the scan data, measurement of bone strength and	Policy (CPCP).		
	BMD and classification of any vertebral fractures, with overall fracture-risk			
	assessment, interpretation and report			
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	3 12/31/2999
	ultrasound imaging guidance, when performed, including autogenous or	Not subject to pre-service review. Check EIU policy,		
	nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium),	which is one of our Clinical Payment and Coding		
	when performed	Policy (CPCP).		
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
07 111	ultrasound imaging guidance, when performed, including autogenous or	Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
	nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium),	which is one of our Clinical Payment and Coding		
	when performed	Policy (CPCP).		
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia;	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	noninvasive arrhythmia localization and mapping of arrhythmia site	Medical Policy Criteria. Submit for Recommended		12/01/2000
	(nidus), derived from anatomical image data (eg, CT, MRI, or myocardial	Clinical Review to avoid post-service review.		
	perfusion scan) and electrical data (eg, 12-lead ECG data), and			
	identification of areas of avoidance			
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	of arrhythmia localization and mapping of arrhythmia site (nidus) into a	Medical Policy Criteria. Submit for Recommended	0/10/2020	1213112338
	multidimensional radiation treatment plan			
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of	Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0/4/1			0/15/2025	12/31/2999
	radiation therapy, arrhythmia	Medical Policy Criteria. Submit for Recommended		
0740	Injections of stom call product into a mismal posificitular and the	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
0748T	Injections of stem cell product into perianal perifistular soft tissue,	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	3 12/31/2999
	including fistula preparation (eg, removal of setons, fistula curettage,	Not subject to pre-service review. Check EIU policy,		
	closure of internal openings)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

0748T		EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/20	23 12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0767T	electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/20	23 12/31/2999
0767T	electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0770T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/20	23 12/31/2999
0770T	code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/20	23 12/31/2999

0771T	Virtual reality (VR) procedural dissociation services provided by the same	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional performing the	Not subject to pre-service review. Check EIU policy,		
	diagnostic or therapeutic service that the VR procedural dissociation	which is one of our Clinical Payment and Coding		
	supports, requiring the presence of an independent, trained observer to	Policy (CPCP).		
	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	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional performing the	Not subject to pre-service review. Check EIU policy,		
	diagnostic or therapeutic service that the VR procedural dissociation	which is one of our Clinical Payment and Coding		
	supports, requiring the presence of an independent, trained observer to	Policy (CPCP).		
	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)			
0772T	Virtual reality (VR) procedural dissociation services provided by the same	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional performing the	Not subject to pre-service review. Check EIU policy,		
	diagnostic or therapeutic service that the VR procedural dissociation	which is one of our Clinical Payment and Coding		
	supports, requiring the presence of an independent, trained observer to	Policy (CPCP).		
	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)			
0773T	Virtual reality (VR) procedural dissociation services provided by a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional other than the	Not subject to pre-service review. Check EIU policy,		
	physician or other qualified health care professional performing the	which is one of our Clinical Payment and Coding		
	diagnostic or therapeutic service that the VR procedural dissociation	Policy (CPCP).		
	supports; initial 15 minutes of intraservice time, patient age 5 years or			
	older			
0773T	Virtual reality (VR) procedural dissociation services provided by a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional other than the	Not subject to pre-service review. Check EIU policy,		
	physician or other qualified health care professional performing the	which is one of our Clinical Payment and Coding		
	diagnostic or therapeutic service that the VR procedural dissociation	Policy (CPCP).		
	supports; initial 15 minutes of intraservice time, patient age 5 years or			
	older			
0774T	Virtual reality (VR) procedural dissociation services provided by a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional other than the	Not subject to pre-service review. Check EIU policy,		
	physician or other qualified health care professional performing the	which is one of our Clinical Payment and Coding		
	diagnostic or therapeutic service that the VR procedural dissociation	Policy (CPCP).		
	supports; each additional 15 minutes intraservice time (List separately in			
	addition to code for primary service)			
0774T	Virtual reality (VR) procedural dissociation services provided by a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	physician or other qualified health care professional other than the	Not subject to pre-service review. Check EIU policy,		
	physician or other qualified health care professional performing the	which is one of our Clinical Payment and Coding		
	diagnostic or therapeutic service that the VR procedural dissociation	Policy (CPCP).		
	supports; each additional 15 minutes intraservice time (List separately in			
	addition to code for primary service)			
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	mechanical temperature-controlled cooling device to the neck over	Not subject to pre-service review. Check EIU policy,		
	carotids and head, including monitoring (eg, vital signs and sport	which is one of our Clinical Payment and Coding		
	concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	Policy (CPCP).		

0776T	Therapeutic induction of intra-brain hypothermia, including placement of a	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
	mechanical temperature-controlled cooling device to the neck over	Not subject to pre-service review. Check EIU policy,			
	carotids and head, including monitoring (eg, vital signs and sport	which is one of our Clinical Payment and Coding			
	concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	Policy (CPCP).			
0777T	Real-time pressure-sensing epidural guidance system (List separately in	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
	addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0777T	Real-time pressure-sensing epidural guidance system (List separately in	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
	addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0778T	Surface mechanomyography (sMMG) with concurrent application of	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	1	9/1/2023	12/31/2999
07701	inertial measurement unit (IMU) sensors for measurement of multi-joint	Not subject to pre-service review. Check EIU policy,		9/1/2023	12/31/2999
	range of motion, posture, gait, and muscle function	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0778T	Surface mechanomyography (sMMG) with concurrent application of	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
	inertial measurement unit (IMU) sensors for measurement of multi-joint	Not subject to pre-service review. Check EIU policy,	0, 1,2020		12/01/2000
	range of motion, posture, gait, and muscle function	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
	interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
	interpretation and report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
07007		Policy (CPCP).			10/01/0000
0780T	Instillation of fecal microbiota suspension via rectal enema into lower	MP Criteria: Procedure/service reviewed against	1/1/2023		12/31/2999
	gastrointestinal tract	Medical Policy Criteria. Submit for Recommended			
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection	Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
07011	device and circumferential radiofrequency destruction of the pulmonary	Not subject to pre-service review. Check EIU policy,		9/1/2023	12/31/2999
	nerves, including fluoroscopic guidance when performed; bilateral	which is one of our Clinical Payment and Coding			
	mainstem bronchi	Policy (CPCP).			
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
01011	device and circumferential radiofrequency destruction of the pulmonary	Not subject to pre-service review. Check EIU policy,	0/ 1/2020		12/01/2000
	nerves, including fluoroscopic guidance when performed; bilateral	which is one of our Clinical Payment and Coding			
	mainstem bronchi	Policy (CPCP).			
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
	device and circumferential radiofrequency destruction of the pulmonary	Not subject to pre-service review. Check EIU policy,			
	nerves, including fluoroscopic guidance when performed; unilateral	which is one of our Clinical Payment and Coding			
	mainstem bronchus	Policy (CPCP).			
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
	device and circumferential radiofrequency destruction of the pulmonary	Not subject to pre-service review. Check EIU policy,			
	nerves, including fluoroscopic guidance when performed; unilateral	which is one of our Clinical Payment and Coding			
	mainstem bronchus	Policy (CPCP).			

0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	patient education on use of equipment	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	patient education on use of equipment	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0784T	Insertion or replacement of percutaneous electrode array, spinal, with	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	integrated neurostimulator, including imaging guidance, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0785T	Revision or removal of neurostimulator electrode array, spinal, with	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	integrated neurostimulator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0786T	Insertion or replacement of percutaneous electrode array, sacral, with	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	integrated neurostimulator, including imaging guidance, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0787T	Revision or removal of neurostimulator electrode array, sacral, with	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	integrated neurostimulator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0788T	Electronic analysis with simple programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	neurostimulation system (eg, electrode array and receiver), including	Medical Policy Criteria. Submit for Recommended		
	contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling,	Clinical Review to avoid post-service review.		
	burst, dose lockout, patient-selectable parameters, responsive			
	neurostimulation, detection algorithms, closed-loop parameters, and			
	passive parameters, when performed by physician or other qualified			
0700 <b>7</b>	health care professional, spinal cord or sacral nerve, 1-3 parameters		0// 5/000 /	10/01/0000
0789T	Electronic analysis with complex programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	neurostimulation system (eg, electrode array and receiver), including	Medical Policy Criteria. Submit for Recommended		
	contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling,	Clinical Review to avoid post-service review.		
	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			
0700T	parameters	Fill Dress dame to smith a sector barrier barrier date that Disc	E/4 E/000 A	40/04/0000
0790T	Revision (eg, augmentation, division of tether), replacement, or removal	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	of thoracolumbar or lumbar vertebral body tethering, including	Not subject to pre-service review. Check EIU policy,		
	thoracoscopy, when performed	which is one of our Clinical Payment and Coding		
0700T	Devision (on augustation division of tather) werks are serviced	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	E/4E/0004	40/04/0000
0790T	Revision (eg, augmentation, division of tether), replacement, or removal	-	5/15/2024	12/31/2999
	of thoracolumbar or lumbar vertebral body tethering, including	Not subject to pre-service review. Check EIU policy,		
	thoracoscopy, when performed	which is one of our Clinical Payment and Coding		
0790T	Devision (or augmentation division of tables) and a second second	Policy (CPCP).	2/15/2024	E/14/2024
	Revision (eg, augmentation, division of tether), replacement, or removal	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	of thoracolumbar or lumbar vertebral body tethering, including	Medical Policy Criteria. Submit for Recommended		
0704T	thoracoscopy, when performed	Clinical Review to avoid post-service review.	714100000	40/04/0000
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training,	EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
	each 15 minutes (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,		
	procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training,	EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
	each 15 minutes (List separately in addition to code for primary	Not subject to pre-service review. Check EIU policy,		
	procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	pulmonary arteries, including right heart catheterization, pulmonary artery	Medical Policy Criteria. Submit for Recommended		
	angiography, and all imaging guidance	Clinical Review to avoid post-service review.		
0795T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	including imaging guidance (eg, fluoroscopy, venous ultrasound, right	Medical Policy Criteria. Submit for Recommended		
	atrial angiography, right ventriculography, femoral venography) and device	Clinical Review to avoid post-service review.		
	evaluation (eg, interrogation or programming), when performed; complete			
	system (ie, right atrial and right ventricular pacemaker components)			
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
0/001	including imaging guidance (eg, fluoroscopy, venous ultrasound, right	Medical Policy Criteria. Submit for Recommended	11 11 2020	12/01/2000
	atrial angiography, right ventriculography, femoral venography) and device			
	evaluation (eg, interrogation or programming), when performed; right atrial			
	pacemaker component (when an existing right ventricular single leadless			
	pacemaker exists to create a dual-chamber leadless pacemaker system)			
			7///0000	10/01/0000
0797T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device	Medical Policy Criteria. Submit for Recommended		
	evaluation (eg, interrogation or programming), when performed; right	Cirrical Review to avoid post-service review.		
	ventricular pacemaker component (when part of a dual-chamber leadless			
	pacemaker system)			
0798T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	including imaging guidance (eg, fluoroscopy, venous ultrasound, right	Medical Policy Criteria. Submit for Recommended		
	atrial angiography, right ventriculography, femoral venography), when	Clinical Review to avoid post-service review.		
	performed; complete system (ie, right atrial and right ventricular			
	pacemaker components)			
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	including imaging guidance (eg, fluoroscopy, venous ultrasound, right	Medical Policy Criteria. Submit for Recommended		
	atrial angiography, right ventriculography, femoral venography), when	Clinical Review to avoid post-service review.		
0800T	performed; right atrial pacemaker component Transcatheter removal of permanent dual-chamber leadless pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00001	including imaging guidance (eg, fluoroscopy, venous ultrasound, right	Medical Policy Criteria. Submit for Recommended	111/2023	12/31/2999
	atrial angiography, right ventriculography, femoral venography), when	Clinical Review to avoid post-service review.		
	performed; right ventricular pacemaker component (when part of a dual-			
	chamber leadless pacemaker system)			
0801T	Transcatheter removal and replacement of permanent dual-chamber	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous			
	ultrasound, right atrial angiography, right ventriculography, femoral	Clinical Review to avoid post-service review.		
	venography) and device evaluation (eg, interrogation or programming),			
	when performed; dual-chamber system (ie, right atrial and right ventricular			
	pacemaker components)			

0802T	Transcatheter removal and replacement of permanent dual-chamber	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous	Medical Policy Criteria. Submit for Recommended		
	ultrasound, right atrial angiography, right ventriculography, femoral	Clinical Review to avoid post-service review.		
	venography) and device evaluation (eg, interrogation or programming),			
	when performed; right atrial pacemaker component			
0803T	Transcatheter removal and replacement of permanent dual-chamber	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous			
	ultrasound, right atrial angiography, right ventriculography, femoral	Clinical Review to avoid post-service review.		
	venography) and device evaluation (eg, interrogation or programming),			
	when performed; right ventricular pacemaker component (when part of a			
	dual-chamber leadless pacemaker system)			
0804T	Programming device evaluation (in person) with iterative adjustment of	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	implantable device to test the function of device and to select optimal	Medical Policy Criteria. Submit for Recommended	.,0_0	
	permanent programmed values, with analysis, review, and report, by a	Clinical Review to avoid post-service review.		
	physician or other qualified health care professional, leadless pacemaker			
	system in dual cardiac chambers			
0805T	Transcatheter superior and inferior vena cava prosthetic valve	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00001	implantation (ie, caval valve implantation [CAVI]); percutaneous femoral	Medical Policy Criteria. Submit for Recommended	11 112020	12/01/2000
	vein approach	Clinical Review to avoid post-service review.		
0806T	Transcatheter superior and inferior vena cava prosthetic valve	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00001	implantation (ie, caval valve implantation [CAVI]); open femoral vein	Medical Policy Criteria. Submit for Recommended	1/1/2023	12/31/2999
		5		
0807T	approach Pulmonary tissue ventilation analysis using software-based processing of	Clinical Review to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
00071	data from separately captured cinefluorograph images; in combination		1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
	with previously acquired computed tomography (CT) images, including	which is one of our Clinical Payment and Coding		
	data preparation and transmission, quantification of pulmonary tissue	Policy (CPCP).		
000 <del>7</del> T	ventilation, data review, interpretation and report		7/4/0000	40/04/0000
0807T	Pulmonary tissue ventilation analysis using software-based processing of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
	data from separately captured cinefluorograph images; in combination	Not subject to pre-service review. Check EIU policy,		
	with previously acquired computed tomography (CT) images, including	which is one of our Clinical Payment and Coding		
	data preparation and transmission, quantification of pulmonary tissue	Policy (CPCP).		
0000 <del>T</del>	ventilation, data review, interpretation and report		7///0000	10/04/0000
0808T	Pulmonary tissue ventilation analysis using software-based processing of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
	data from separately captured cinefluorograph images; in combination	Not subject to pre-service review. Check EIU policy,		
	with computed tomography (CT) images taken for the purpose of	which is one of our Clinical Payment and Coding		
	pulmonary tissue ventilation analysis, including data preparation and	Policy (CPCP).		
	transmission, quantification of pulmonary tissue ventilation, data review,			
	interpretation and report			
0808T	Pulmonary tissue ventilation analysis using software-based processing of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2023	12/31/2999
	data from separately captured cinefluorograph images; in combination	Not subject to pre-service review. Check EIU policy,		
	with computed tomography (CT) images taken for the purpose of	which is one of our Clinical Payment and Coding		
	pulmonary tissue ventilation analysis, including data preparation and	Policy (CPCP).		
	transmission, quantification of pulmonary tissue ventilation, data review,			
	interpretation and report			
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	or more retinotomies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0811T	Remote multi-day complex uroflowmetry (eg, calibrated electronic	Non Covered: Procedure/service not covered by the	1/1/2024	12/31/2999
	equipment); set-up and patient education on use of equipment	Plan. Not subject to pre-service review.		

0812T	Remote multi-day complex uroflowmetry (eg, calibrated electronic	Non Covered: Procedure/service not covered by the	1/1/2024	12/31/2999
	days	Plan. Not subject to pre-service review.		
0813T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	
0813T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024
0816T	bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	Policy (CPCP).	7/1/2024	12/31/2999
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	Policy (CPCP).	7/1/2024	12/31/2999
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999

0825T	Transcatheter removal and replacement of permanent single-chamber	MP Criteria: Procedure/service reviewed against	5/15/2024		12/31/2999
00201	leadless pacemaker, right atrial, including imaging guidance (eg,	Medical Policy Criteria. Submit for Recommended	0, 10,202 .		12/01/2000
	fluoroscopy, venous ultrasound, right atrial angiography and/or right	Clinical Review to avoid post-service review.			
	ventriculography, femoral venography, cavography) and device evaluation	•			
	(eq, interrogation or programming), when performed	1			
0826T	Programming device evaluation (in person) with iterative adjustment of	MP Criteria: Procedure/service reviewed against	5/15/2024		12/31/2999
	the implantable device to test the function of the device and select optima				
	permanent programmed values with analysis, review and report by a	Clinical Review to avoid post-service review.			
	physician or other qualified health care professional, leadless pacemaker				
	system in single-cardiac chamber				
0858T	Externally applied transcranial magnetic stimulation with concomitant	EIU: Procedure/service not reimbursed by the Plan.		10/1/2024	12/31/2999
	measurement of evoked cortical potentials with automated report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0858T	Externally applied transcranial magnetic stimulation with concomitant	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
	measurement of evoked cortical potentials with automated report	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
0858T	Externally applied transcranial magnetic stimulation with concomitant	MP Criteria: Procedure/service reviewed against	6/1/2024		9/30/2024
	measurement of evoked cortical potentials with automated report	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
0861T	Removal of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	ventricular pacing; both components (battery and transmitter)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
0862T	Relocation of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	ventricular pacing, including device interrogation and programming;	Medical Policy Criteria. Submit for Recommended			
	battery component only	Clinical Review to avoid post-service review.			
0863T	Relocation of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024		12/31/2999
	ventricular pacing, including device interrogation and programming;	Medical Policy Criteria. Submit for Recommended			
	transmitter component only	Clinical Review to avoid post-service review.			
0864T	Low-intensity extracorporeal shock wave therapy involving corpus	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
	cavernosum, low energy	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
000/7		Policy (CPCP).			10/01/0000
0864T	Low-intensity extracorporeal shock wave therapy involving corpus	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
	cavernosum, low energy	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
000 IT		Policy (CPCP).	4/4/0004		0/00/0004
0864T	Low-intensity extracorporeal shock wave therapy involving corpus	MP Criteria: Procedure/service reviewed against	4/1/2024		6/30/2024
	cavernosum, low energy	Medical Policy Criteria. Submit for Recommended			
00707		Clinical Review to avoid post-service review.	0/4/2024		40/04/0000
0870T	Implantation of subcutaneous peritoneal ascites pump system,	MP Criteria: Procedure/service reviewed against	9/1/2024		12/31/2999
	percutaneous, including pump-pocket creation, insertion of tunneled	Medical Policy Criteria. Submit for Recommended			
	indwelling bladder and peritoneal catheters with pump connections,	Clinical Review to avoid post-service review.			
0871T	including all imaging and initial programming, when performed	MP Criteria: Procedure/service reviewed against	9/1/2024		12/31/2999
00711	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal	Medical Policy Criteria. Submit for Recommended	9/1/2024		12/31/2999
	catheters, including initial programming and imaging, when performed	Clinical Review to avoid post-service review.			
ļ	reameters, monuning milital programming and imaging, when performed		I		

0872T	Replacement of indwelling bladder and peritoneal catheters, including	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
00721	tunneling of catheter(s) and connection with previously implanted	Medical Policy Criteria. Submit for Recommended	5/ 1/2024	12/01/2000
	peritoneal ascites pump, including imaging and programming, when	Clinical Review to avoid post-service review.		
	performed	Clinical Review to avoid post-service review.		
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system,	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	any component (ascites pump, associated peritoneal catheter, associated	Medical Policy Criteria, Submit for Recommended		
	bladder catheter), including imaging and programming, when performed	Clinical Review to avoid post-service review.		
	bladdor oddrotor), moldarig magnig and programming, mon poromod			
0874T	Removal of a peritoneal ascites pump system, including implanted	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	peritoneal ascites pump and indwelling bladder and peritoneal catheters	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0875T	Programming of subcutaneously implanted peritoneal ascites pump	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	system by physician or other qualified health care professional	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A0021	Ambulance service, outside state per mile, transport (medicaid only)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0080	Non-emergency transportation, per mile - vehicle provided by volunteer	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	(individual or organization), with no vested interest	Plan. Not subject to pre-service review.		
A0090	Non-emergency transportation, per mile - vehicle provided by individual	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	(family member, self, neighbor) with vested interest	Plan. Not subject to pre-service review.		
A0100	Non-emergency transportation; taxi	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0110	Non-emergency transportation and bus, intra or inter state carrier	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0120	Non-emergency transportation: mini-bus, mountain area transports, or	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	other transportation systems	Plan. Not subject to pre-service review.		
A0130	Non-emergency transportation: wheel-chair van	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0140	Non-emergency transportation and air travel (private or commercial) intra	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	or inter state	Plan. Not subject to pre-service review.		
A0160	Non-emergency transportation: per mile - case worker or social worker	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0170	Transportation ancillary: parking fees, tolls, other	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0180	Non-emergency transportation: ancillary: lodging-recipient	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0190	Non-emergency transportation: ancillary: meals-recipient	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0200	Non-emergency transportation: ancillary: lodging escort	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0210	Non-emergency transportation: ancillary: meals-escort	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0225	Ambulance service, neonatal transport, base rate, emergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	one way	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		

.0380	BLS mileage	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0382	Basic Life Support (BLS) routine disposable supplies	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(Advanced Life Support) ambulances and BLS ambulances in	Medical Policy Criteria. Submit for Recommended	17 17 20 20	12/01/2000
	jurisdictions where defibrillation is permitted in BLS ambulances)	Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0390	ALS mileage	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
/ 10000		Medical Policy Criteria. Submit for Recommended	17 17 2020	12/01/2000
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0392	ALS specialized service disposable supplies; defibrillation (to be used	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
10002	only in jurisdictions where defibrillation cannot be performed by BLS	Medical Policy Criteria. Submit for Recommended	17 17 2020	12/01/2000
	ambulances)	Clinical Review to avoid post-service review. This		
	ambalanoosy	code is managed by Alacura.		
A0394	ALS specialized service disposable supplies; IV drug therapy	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1, 1/2020	12/01/2000
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0396	ALS specialized service disposable supplies; esophageal intubation	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
/ 10000		Medical Policy Criteria. Submit for Recommended	17 17 2020	12/01/2000
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0398	ALS routine disposable supplies	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour increments	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	situation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	winged); (requires medical review)	Medical Policy Criteria. 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	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1/1/2020	12/01/2000
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
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A0426	Ambulance service, advanced life support, non-emergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	Level 1 (ALS1)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0426	Ambulance service, advanced life support, non-emergency transport,	MP Criteria: Procedure/service reviewed against	9/15/2014	12/31/2999
	level 1 (als 1)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0427	Ambulance service, advanced life support, emergency transport, Level 1	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(ALS1-Emergency)	Medical Policy Criteria. 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 (BLS)	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0429	Ambulance service, basic life support, emergency transport (BLS-	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	Emergency)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0431	Ambulance service, conventional air services, transport, one way (rotary	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0431	Ambulance service, conventional air services, transport, one way (rotary	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
	wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	ambulance company which is prohibited by state law from billing third	Medical Policy Criteria. Submit for Recommended		
	party payers	Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0433	Advanced life support, Level 2 (ALS2)	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0434	Specialty care transport (SCT)	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0888	Noncovered ambulance mileage, per mile (e. G., for miles traveled	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	beyond closest appropriate facility)	Plan. Not subject to pre-service review.		

A0998	Ambulance response and treatment, no transport	MP Criteria: Procedure/service reviewed against		1/1/2025	12/31/2999
		Medical Policy Criteria. 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.		4/15/2022	12/31/2999
		Not subject to pre-service 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.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,	.,		12/01/2000
		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.		4/15/2022	12/31/2999
	······································	Not subject to pre-service 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.	4/15/2022		12/31/2999
		Not subject to pre-service 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.		4/15/2022	12/31/2999
		Not subject to pre-service 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.	4/15/2022		12/31/2999
		Not subject to pre-service 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.		4/15/2022	12/31/2999
		Not subject to pre-service 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.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
	5 ,1 1	Not subject to pre-service 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.		4/15/2022	12/31/2999
		Not subject to pre-service 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.	4/15/2022		12/31/2999
	-7	Not subject to pre-service 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.		4/15/2022	12/31/2999
		Not subject to pre-service 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.	4/15/2022		12/31/2999
		Not subject to pre-service 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.		8/1/2022	12/31/2999
		Not subject to pre-service 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.	8/1/2022		12/31/2999
		Not subject to pre-service 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.		8/1/2022	12/31/2999
		Not subject to pre-service 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.	8/1/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan.		4/1/2023	12/31/2999
	5 ,1 5 5	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023		12/31/2999
	······································	Not subject to pre-service review. Check EIU policy,			,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/1/2023	12/31/2999
12010		Not subject to pre-service review. Check EIU policy,		1, 1, 2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023		12/31/2999
12010		Not subject to pre-service review. Check EIU policy,			12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/1/2023	12/31/2999
12010		Not subject to pre-service review. Check EIU policy,		4/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023		12/31/2999
A2010	r enneadenn b, per square centimeter	Not subject to pre-service review. Check EIU policy,	4/1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan.		4/1/2023	12/31/2999
	r enheadenn giove, each	Not subject to pre-service review. Check EIU policy,		4/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023		12/31/2999
A2011	r childadani giove, each	Not subject to pre-service review. Check EIU policy,	4/1/2020		12/01/2000
		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.		4/1/2023	12/31/2999
A2010		Not subject to pre-service review. Check EIU policy,		4/1/2020	12/01/2000
		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.	4/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,	-1/2020		12/01/2000
		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.		9/1/2023	12/31/2999
AZU 19	nereois ornegas mangen smeid, per square centimeter	Not subject to pre-service review. Check EIU policy,		9/1/2023	12/31/2999
		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.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan.	9/1	/2023 12/31/2999
	·····	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
/ 2020		Not subject to pre-service review. Check EIU policy,	0, 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1	/2023 12/31/2999
12021		Not subject to pre-service review. Check EIU policy,	0/1	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,	5/1/2025	12/01/2000
		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.	10/1	/2023 12/31/2999
AZUZZ		Not subject to pre-service review. Check EIU policy,	10/1	12/01/2000
		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.	10/1/2023	12/31/2999
AZUZZ		Not subject to pre-service review. Check EIU policy,	10/1/2023	12/3/12999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	10/1	/2023 12/31/2999
A2023	Innovaniatix pu, i ng	Not subject to pre-service review. Check EIU policy,	10/1	12023 12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
A2023	innovaniatix pu, i ng	Not subject to pre-service review. Check EIU policy,	10/1/2023	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2024	Resolve matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1	/2023 12/31/2999
A2024	Resolve matrix, per square centimeter	Not subject to pre-service review. Check EIU policy,	10/1	12023 12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2024	Resolve matrix or xenopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
AZUZ4	incourse mains of senopaton, per square centimeter	Not subject to pre-service review. Check EIU policy,	10/1/2023	12/31/2999
		which is one of our Clinical Payment and Coding		
A 2025	Mire2d per outin continets:	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	40/4	12022
A2025	Miro3d, per cubic centimeter		10/1	/2023 12/31/2999
		Not subject to pre-service 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.	10/1/2023	12/31/2999
		Not subject to pre-service 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.	4/1/2024	12/31/2999
		Not subject to pre-service 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.	4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
1 1 1 0 0		Policy (CPCP).	4/4/0000	40/04/0000
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
A4244	Alcohol or peroxide, per pint	Clinical Review to avoid post-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A4244		Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4246	Betadine or phisohex solution, per pint	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A4240	betadine of phisonex solution, per pint	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4247	Betadine or iodine swabs/wipes, per box	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	Betadine of loune swabs/wipes, per box	Plan. Not subject to pre-service review.	1/1/1000	12/01/2000
A4335	Incontinence supply; miscellaneous	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
11000		Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
A4341	Indwelling intraurethral drainage device with valve, patient inserted,	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	replacement only, each	Medical Policy Criteria. Submit for Recommended		
	, ,,,	Clinical Review to avoid post-service review.		
A4342	Accessories for patient inserted indwelling intraurethral drainage device	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	with valve, replacement only, each	Medical Policy Criteria. 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	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4452	Tape, waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4458	Enema bag with tubing, reusable	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4465	Non-elastic binder for extremity	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4490	Surgical stockings above knee length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4495	Surgical stockings thigh length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
4 4 5 0 0		Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
A4500	Surgical stockings below knee length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
1 4540		Plan. Not subject to pre-service review.	4/4/4050	10/01/0000
A4510	Surgical stockings full length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
4 4 5 0 0		Plan. Not subject to pre-service review.	4/4/0005	40/04/0000
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH		1/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		

A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
	nerves of the upper arm	Not subject to pre-service review. Check EIU policy,		0/10/2021	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
	nerves of the upper arm	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
	nerves of the upper arm	Medical Policy Criteria. Submit for Recommended	2,10,2021		0/1 1/2021
		Clinical Review to avoid post-service review.			
A4541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against	2/15/2024		12/31/2999
		Medical Policy Criteria. Submit for Recommended	2/10/2021		12/01/2000
		Clinical Review to avoid post-service review.			
A4542	Supplies and accessories for external upper limb tremor stimulator of the	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024	12/31/2999
7(1012	peripheral nerves of the wrist	Not subject to pre-service review. Check EIU policy,		0/10/2024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A4542	Supplies and accessories for external upper limb tremor stimulator of the	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024		12/31/2999
111012	peripheral nerves of the wrist	Not subject to pre-service review. Check EIU policy,	0/10/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
A4542	Supplies and accessories for external upper limb tremor stimulator of the	MP Criteria: Procedure/service reviewed against	2/15/2024		5/14/2024
A4042	peripheral nerves of the wrist	Medical Policy Criteria. Submit for Recommended	2/13/2024		5/14/2024
	periprieral herves of the wrist	Clinical Review to avoid post-service review.			
A4554	Disposable underpads, all sizes	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
74004	Disposable underpads, all sizes	Plan. Not subject to pre-service review.	1/ 1/ 1950		12/31/2999
A4555	Electrode/transducer for use with electrical stimulation device used for	MP Criteria: Procedure/service reviewed against	6/15/2017		12/31/2999
74000	cancer treatment, replacement only	Medical Policy Criteria. Submit for Recommended	0/10/2017		12/01/2000
	cancer treatment, replacement only	Clinical Review to avoid post-service review.			
A4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
74000	(E.G., TENS, NMES), PER OZ	Plan. Not subject to pre-service review.	1/ 1/ 1950		12/31/2999
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only			1/15/2024	12/31/2999
A4300		Not subject to pre-service review. Check EIU policy,		1/13/2024	12/31/2999
		which is one of our Clinical Payment and Coding			
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	Policy (CPCP).	1/15/2024		12/31/2999
A4500		Not subject to pre-service review. Check EIU policy,	1/15/2024		12/31/2999
		which is one of our Clinical Payment and Coding			
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	Policy (CPCP).	10/15/2022		1/11/2024
A4560	inteuromuscular electrical sumulator (nmes), disposable, replacement only		10/15/2023		1/14/2024
		Medical Policy Criteria. Submit for Recommended			
	Tanial humanhania ang manahang bara di marak k	Clinical Review to avoid post-service review.		40/4/0000	40/04/0000
A4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

A4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	······································	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories,	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
	per month	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories,		4/1/2023	12/31/2999
	per month	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE,	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	REPLACEMENT ONLY, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4638	Replacement battery for patient-owned ear pulse generator, each	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4639	Replacement pad for infrared heating pad system, each	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4639	Replacement pad for infrared heating pad system, each	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A4890	Contracts, repair and maintenance, for hemodialysis equipment	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4927	Gloves, non-sterile, per 100	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4931	Oral thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4932	Rectal thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	0///0000	10/04/0000
A6000	Non-contact wound warming wound cover for use with the non-contact	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	wound warming device and warming card	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
10000		Policy (CPCP).	0/4/0000	40/04/0000
A6000	Non-contact wound warming wound cover for use with the non-contact	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	wound warming device and warming card	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
10040	Course non immediatel non starile nod size 40 on In. Onlass without	Policy (CPCP).	4/4/4050	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	1/1/1950	12/31/2999
AC047		Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	40/04/0000
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But		1/1/1950	12/31/2999
A6218	less than or equal to 48 sq. In. , without adhesive border, each dressing Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In. ,	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
AUZ 10			1/1/1950	12/31/2999
A6530	without adhesive border, each dressing Gradient compression stocking, below knee, 18-30 mmhg, each	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
A0000	Gradient compression stocking, below knee, 10-50 mining, each	-	1/1/2000	12/31/2999
		Plan. Not subject to pre-service review.	1	

A6531	Gradient compression stocking, below knee, 30-40 mmhg, used as a	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
70331	surgical dressing, each	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2333
A6533	Gradient compression stocking, thigh length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
A0000	Gradient compression stocking, ungritengur, 10-50 mining, each	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2333
A6534	Gradient compression stocking, thigh length, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
A0004	Gradient compression stocking, ungritengur, 50-40 mining, each	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2333
A6536	Gradient compression stocking, full length/chap style, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
70330	Oraclent compression stocking, full length on ap style, 10-00 mining, each	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2333
A6537	Gradient compression stocking, full length/chap style, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
10001		Plan. Not subject to pre-service review.	17 17 2000	12/01/2000
A6539	Gradient compression stocking, waist length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
10000		Plan. Not subject to pre-service review.	17 17 2000	12/01/2000
A6540	Gradient compression stocking, waist length, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	······································	Plan. Not subject to pre-service review.		
A6544	Gradient compression stocking, garter belt	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
A6549	Gradient compression garment, not otherwise specified	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
A7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A9150	Non-prescription drugs	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A9152	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE,	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	NOT OTHERWISE SPECIFIED	Plan. Not subject to pre-service review.		
A9153	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Plan. Not subject to pre-service review.		
A9270	Non-covered item or service	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
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	1/1/2011	12/31/2999
		Plan. Not subject to pre-service review.		
A9282	WIG, ANY TYPE, EACH	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
A9285	Inversion/eversion correction device	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A9285	Inversion/eversion correction device	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	1/31/2024
	course of treatment	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	1/31/2024
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
	course of treatment	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9300	Exercise equipment	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
B4102	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	Plan. Not subject to pre-service review.		
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	Plan. Not subject to pre-service review.		
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
Diriot		Plan. Not subject to pre-service review.	11 11 2000	12/01/2000
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
2		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
	CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE	, , ,		
	FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE,			
	100 CALORIES = 1 UNIT			
B4150		Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
	administered through an enteral feeding tube, 100 calories = 1 unit			
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats,	Plan. Not subject to pre-service review.		
	carbohydrates, vitamins and minerals, may include fiber, administered			
	through an enteral feeding tube, 100 calories = 1 unit			
B4154		Non Covered: Procedure/service not covered by the	1/1/2013	12/31/2999
	excludes inherited disease of metabolism, includes altered composition of	Plan. Not subject to pre-service review.		
	proteins, fats, carbohydrates, vitamins 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	1/1/2005	12/31/2999
	COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS,	Plan. Not subject to pre-service review.		
	CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER			
	AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING			
	TUBE, 100 CALORIES = 1 UNIT			
B4159		Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES	Plan. Not subject to pre-service review.		
	PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS,			
	MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN			
	ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT			

B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS,	Plan. Not subject to pre-service review.		
	FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE			
	FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT			
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	ml = 1 unit) - homemix	Plan. Not subject to pre-service review.		
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
C1062	Intravertebral body fracture augmentation with implant (e.g., metal,	Policy (CPCP). MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
61062		Medical Policy Criteria. Submit for Recommended	3/15/2024	12/31/2999
	polymer)	Clinical Review to avoid post-service review.		
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
01000	implantable components), rate-responsive, including all necessary	Medical Policy Criteria. Submit for Recommended	11 11 2024	12/01/2000
	components for implantation	Clinical Review to avoid post-service review.		
C1761	Catheter, transluminal intravascular lithotripsy, coronary	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
C1764	Event recorder, cardiac	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1778	Lead, neurostimulator	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.1700		Clinical Review to avoid post-service review.	0// 5/00/ 5	10/01/0000
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against	3/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
C1817	Septal defect imp sys	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	4/15/2014	12/31/2999
01017	Septal delect imp sys	Medical Policy Criteria. Submit for Recommended	4/15/2014	12/31/2999
		Clinical Review to avoid post-service review.		
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
01010		Medical Policy Criteria. Submit for Recommended	1/ 1/2013	12/01/2000
		Clinical Review to avoid post-service review.		
C1820	Generator, neurostimulator (implantable), with rechargeable battery and	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	charging system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1822	Generator, neurostimulator (implantable), high frequency, with	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
-	rechargeable battery and charging system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

C1823	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	4/1/202	2 12/31/2999
	transvenous sensing and stimulation leads	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1823	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
	transvenous sensing and stimulation leads	Not subject to pre-service review. Check EIU policy,		
	5	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1824	Generator, cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	sinus baroreceptor stimulation lead(s)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1826	Generator, neurostimulator (implantable), includes closed feedback loop	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	leads and all implantable components, with rechargeable battery and	Medical Policy Criteria. Submit for Recommended		
	charging system	Clinical Review to avoid post-service review.		
C1827	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	9/1/202	3 12/31/2999
	implantable stimulation lead and external paired stimulation controller	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1827	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	implantable stimulation lead and external paired stimulation controller	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1832	Autograft suspension, including cell processing and application, and all	EIU: Procedure/service not reimbursed by the Plan.	5/15/202	12/31/2999
	system components	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1832	Autograft suspension, including cell processing and application, and all	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	system components	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1832	Autograft suspension, including cell processing and application, and all	MP Criteria: Procedure/service reviewed against	2/1/2024	5/14/2024
	system components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1833	Monitor, cardiac, including intracardiac lead and all system components	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(implantable)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	MP Criteria: Procedure/service reviewed against	5/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2624	Implantable wireless pulmonary artery pressure sensor with delivery	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	catheter, including all system components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area up to 100 sq cm; first 25 sq cm or less wound surface	Medical Policy Criteria. Submit for Recommended		
	area	Clinical Review to avoid post-service review.		

C5272		MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area up to 100 sq cm; each additional 25 sq cm wound	Medical Policy Criteria. Submit for Recommended		
	surface area, or part thereof (list separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area greater than or equal to 100 sq cm; first 100 sq cm	Medical Policy Criteria. Submit for Recommended		
	wound surface area, or 1% of body area of infants and children	Clinical Review to avoid post-service review.		
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area greater than or equal to 100 sq cm; each additional	Medical Policy Criteria. Submit for Recommended		
	100 sq cm wound surface area, or part thereof, or each additional 1% of	Clinical Review to avoid post-service review.		
	body area of infants and children, or part thereof (list separately in			
	addition to code for primary procedure)			
C5275		MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	wound surface area up to 100 sq cm; first 25 sq cm or less wound surface			
	area			
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended		
	wound surface area up to 100 sq cm; each additional 25 sq cm wound	Clinical Review to avoid post-service review.		
	surface area, or part thereof (list separately in addition to code for primary			
	procedure)			
C5277		MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	wound surface area, or 1% of body area of infants and children			
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
00210		Medical Policy Criteria. Submit for Recommended		12/01/2000
	wound surface area greater than or equal to 100 sq cm; each additional	Clinical Review to avoid post-service review.		
	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)			
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against	5/15/2024	3/31/2024
		Medical Policy Criteria. Submit for Recommended		0/0 //2021
		Clinical Review to avoid post-service review.		
C9161	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against	5/1/2024	3/31/2024
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9168	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against	8/1/2024	6/30/2024
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	) 12/31/2999
	square centimeter	Not subject to pre-service review. Check EIU policy,	,=.	
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	square centimeter	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		in a sine of our on near aymont and obuing		

C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	matrix (TenoGlide Tendon Protector Sheet), per square centimeter	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
00000		Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9358		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
00050	Demoster de Alfrede en etites en en des etimes des Uneres de Altre de estis	Policy (CPCP).	4.0/4/0000	40/04/0000
C9358		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	) 12/31/2999
03300		Not subject to pre-service review. Check EIU policy,	12/1/2020	12/3/12/33
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
00000		Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square	EIU: Procedure/service not reimbursed by the Plan.	5/15/202	1 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9363		EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9364		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	) 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
00004	Density involved Dense of a second second free day	Policy (CPCP).	4.0/4/0000	40/04/0000
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine	Policy (CPCP). MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
03734		Medical Policy Criteria. Submit for Recommended	10/10/2014	1213112333
	leioniyomata, with magnetic resonance (with) guidance	Clinical Review to avoid post-service review.		
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants		12/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended	, .,	
		Clinical Review to avoid post-service review.		
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended	,	
		Clinical Review to avoid post-service review.		1

C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s),	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding		
	anchored annular closure device, including annular defect measurement,	Policy (CPCP).		
	alignment and sizing assessment, and image guidance; 1 interspace,			
	lumbar			
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s),	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	including partial facetectomy, foraminotomy and excision of herniated	Not subject to pre-service review. Check EIU policy,		
	intervertebral disc, and repair of annular defect with implantation of bone	which is one of our Clinical Payment and Coding		
	anchored annular closure device, including annular defect measurement,	Policy (CPCP).		
	alignment and sizing assessment, and image guidance; 1 interspace, lumbar			
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy, includes angioplasty within the same	Medical Policy Criteria. Submit for Recommended		
	vessel(s), when performed	Clinical Review to avoid post-service review.		
C9765	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy, and transluminal stent placement(s),	Medical Policy Criteria. Submit for Recommended		
	includes angioplastyš within the same vessel(s), when performed	Clinical Review to avoid post-service review.		
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy and atherectomy, includes angioplasty within	Medical Policy Criteria. Submit for Recommended		
	the same vessel(s), when performed	Clinical Review to avoid post-service review.		
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy and transluminal stent placement(s), and	Medical Policy Criteria. Submit for Recommended		
	atherectomy, includes angioplasty within the same vessel(s), when	Clinical Review to avoid post-service review.		
	performed			
C9768	Endoscopic ultrasound-guided direct measurement of hepatic	EIU: Procedure/service not reimbursed by the Plan.	3/1/2021	12/31/2999
	portosystemic pressure gradient by any method (list separately in addition			
	to code for primary procedure)	which is one of our Clinical Payment and Coding		
C9768		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	3/1/2021	12/31/2999
C9700	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition		3/1/2021	12/31/2999
	to code for primary procedure)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9769	Cystourethroscopy, with insertion of temporary prostatic implant/stent with	MP Criteria: Procedure/service reviewed against	10/15/2020	12/31/2999
	fixation/anchor and incisional struts	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies), with intravascular lithotripsy, includes angioplasty within the	Not subject to pre-service review. Check EIU policy,		
	same vessel (s), when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies), with intravascular lithotripsy, includes angioplasty within the	Not subject to pre-service review. Check EIU policy,		
	same vessel (s), when performed	which is one of our Clinical Payment and Coding		
00772	Developularization and vaccular area and and the second	Policy (CPCP).	0/45/0004	40/04/0000
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy, and transluminal stent	Not subject to pre-service review. Check EIU policy,		
	placement(s), includes angioplasty within the same vessel(s), when	which is one of our Clinical Payment and Coding		
	performed	Policy (CPCP).		

C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021		12/31/2999
	artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
	performed	Policy (CPCP).			
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding		8/15/2021	12/31/2999
		Policy (CPCP).			
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021		12/31/2999
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		8/15/2021	12/31/2999
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021		12/31/2999
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		8/15/2021	12/31/2999
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021		12/31/2999
C9782	Blinded procedure for new york heart association (nyha) class ii or iii hear failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study	t MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024		12/31/2999
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2023	12/31/2999
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023		12/31/2999
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2023	12/31/2999

C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
00100	and intraluminal tube insertion, if performed, including all system and	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
	tissue anchoring components	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9786	Echocardiography image post processing for computer aided detection of	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
	heart failure with preserved ejection fraction, including interpretation and	Medical Policy Criteria. Submit for Recommended		
	report	Clinical Review to avoid post-service review.		
C9793	3d predictive model generation for pre-planning of a cardiac procedure,	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
	using data from cardiac computed tomographic angiography with report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding	MP Criteria: Procedure/service reviewed against	4/1/2024	6/30/2024
	anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	tooth, and including elevation of mucoperiosteal flap if indicated	Plan. Not subject to pre-service review.		
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
D7230	removal of impacted tooth - partially bony	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0162	Sitz bath chair	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes		10/1/2022	12/31/2999
	heavy duty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0187	Water pressure mattress	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE,	Non Covered: Procedure/service not covered by the	2/1/2010	12/31/2999
	INCLUDES ALL COMPONENTS AND ACCESSORIES	Plan. Not subject to pre-service review.		
E0210	Electric heat pad, standard	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0215	Electric heat pad, moist	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0217	Water circulating heat pad with pump	Non Covered: Procedure/service not covered by the	6/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		

E0218	Fluid circulating cold pad with pump, any type	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
E0221	Infrared heating pad system	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP)		
E0221	Infrared heating pad system	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0231	Non-contact wound warming device (temperature control unit, ac adapter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	and power cord) for use with warming card and wound cover	Not subject to pre-service review. Check EIU policy,		
	1 , 3	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0231	Non-contact wound warming device (temperature control unit, ac adapter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
_0_0	and power cord) for use with warming card and wound cover	Not subject to pre-service review. Check EIU policy,	0/ 1/2020	,
	and ponor cordy for doo man marning card and nound coron	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0232	Warming card for use with the non contact wound warming device and	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
L0202	non contact wound warming wound cover	Not subject to pre-service review. Check EIU policy,	3/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
E0000	Managing and farmers with the new context we were device and	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	0/11/2020	40/04/0000
E0232	Warming card for use with the non contact wound warming device and	-	9/1/2020	12/31/2999
	non contact wound warming wound cover	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0236	Pump for water circulating pad	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
E0240	Bath/shower chair, with or without wheels, any size	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0241	Bath tub wall rail, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0242	Bath tub rail, floor base	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0247	Transfer bench for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	., .,	,
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
20270	opening	Plan. Not subject to pre-service review.	1, 1, 1000	12,0172000
E0249	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT	Non Covered: Procedure/service not covered by the	9/1/2006	12/31/2999
L0249	ONLY		3/1/2000	12/01/2999
E0273	Bed board	Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0273		Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		

E0274	Over-bed table	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
E0280	Bed cradle, any type	Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
L0200	Deu Claule, any type	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
		Clinical Review to avoid post-service review.		
E0291	Hospital bed, fixed height, without side rails, without mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
L0231	Tiospital bed, fixed fielgift, without side fails, without mattless	Medical Policy Criteria. Submit for Recommended	5/15/2014	12/31/2333
		Clinical Review to avoid post-service review.		
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
20233		Medical Policy Criteria. Submit for Recommended	5/15/2014	12/01/2000
		Clinical Review to avoid post-service review.		
E0315	Bed accessory: board, table, or support device, any type	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
20010	bed decessive beard, table, or support device, any type	Plan. Not subject to pre-service review.	17 17 2021	12/01/2000
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
20010		Plan. Not subject to pre-service review.	17 17 2021	12/01/2000
E0462	Rocking bed with or without side rails	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
20402		Plan. Not subject to pre-service review.	1/ 1/ 1000	12/01/2000
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY	MP Criteria: Procedure/service reviewed against	1/1/2006	7/31/2024
20400	COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE,	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	110 112024
	PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Clinical Review to avoid post-service review.		
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
20407		Not subject to pre-service review. Check EIU policy,	0/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
20101		Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0490	Power source and control electronics unit for oral device/appliance for	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	neuromuscular electrical stimulation of the tongue muscle, controlled by	Not subject to pre-service review. Check EIU policy,		
	hardware remote	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0490	Power source and control electronics unit for oral device/appliance for	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	neuromuscular electrical stimulation of the tongue muscle, controlled by	Not subject to pre-service review. Check EIU policy,		
	hardware remote	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0491	Oral device/appliance for neuromuscular electrical stimulation of the	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	tongue muscle, used in conjunction with the power source and control	Not subject to pre-service review. Check EIU policy,		
	electronics unit, controlled by hardware remote, 90-day supply	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0491	Oral device/appliance for neuromuscular electrical stimulation of the	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	tongue muscle, used in conjunction with the power source and control	Not subject to pre-service review. Check EIU policy,		
	electronics unit, controlled by hardware remote, 90-day supply	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0492	Power source and control electronics unit for oral device/appliance for	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	neuromuscular electrical stimulation of the tongue muscle, controlled by	Medical Policy Criteria. Submit for Recommended		
	phone application	Clinical Review to avoid post-service review.		
E0493	Oral device/appliance for neuromuscular electrical stimulation of the	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	tongue muscle, used in conjunction with the power source and control	Medical Policy Criteria. Submit for Recommended		
	electronics unit, controlled by phone application, 90-day supply	Clinical Review to avoid post-service review.		

E0530	Electronic positional obstructive sleep apnea treatment, with sensor,	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	includes all components and accessories, any type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0616	Implantable cardiac event recorder with memory, activator and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
20010	programmer	Medical Policy Criteria. Submit for Recommended	11 11 1000	12/01/2000
	programmer	Clinical Review to avoid post-service review.		
E0617	External defibrillator with integrated electrocardiogram analysis	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0, 10, 2010	
		Clinical Review to avoid post-service review.		
E0620	Skin piercing device for collection of capillary blood, laser, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
20020		Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
E0650	Pneumatic compressor, non-segmental home model	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20000	i noumatio comprocesi, non ocginental nomo model	Medical Policy Criteria. Submit for Recommended	2/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0651	Pneumatic compressor, segmental home model without calibrated	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20001	gradient pressure	Medical Policy Criteria. Submit for Recommended	2/ 1/2000	12/01/2000
	gradient probate	Clinical Review to avoid post-service review.		
E0652	Pneumatic compressor, segmental home model with calibrated gradient	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20002	pressure	Medical Policy Criteria. Submit for Recommended	2/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor,	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20000	half arm	Medical Policy Criteria. Submit for Recommended	2/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	COMPRESSOR, TRUNK	Medical Policy Criteria. Submit for Recommended	., ., 2000	
		Clinical Review to avoid post-service review.		
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	COMPRESSOR, CHEST	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor,	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	full leg	Medical Policy Criteria. Submit for Recommended		
	5	Clinical Review to avoid post-service review.		
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor,	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	full arm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor,	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	half leg	Medical Policy Criteria. Submit for Recommended		
	5	Clinical Review to avoid post-service review.		
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	arm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0670	Segmental pneumatic appliance for use with pneumatic compressor,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	integrated, 2 full legs and trunk	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20071	obginionital gradient procedie priodinatio appliance, fair log	Medical Policy Criteria. Submit for Recommended	2, 172000	12/01/2000
		Clinical Review to avoid post-service review.		
E0672	Segmental gradient pressure pneumatic appliance, full arm	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
20072	ocginental gradient pressure prodinatio appliance, fuil ann	Medical Policy Criteria. Submit for Recommended	2/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0673	Segmental gradient pressure pneumatic appliance, half leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	_, ., _ 0 0 0	12/01/2000
		Clinical Review to avoid post-service review.		
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	cycle, for arterial insufficiency (unilateral or bilateral system)	Not subject to pre-service review. Check EIU policy,		
	-,,, (	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	cycle, for arterial insufficiency (unilateral or bilateral system)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	ACCESSORIES), NOT OTHERWISE SPECIFIED	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0677	Non-pneumatic sequential compression garment, trunk	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0678	Non-pneumatic sequential compression garment, full leg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0679	Non-pneumatic sequential compression garment, half leg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0680	Non-pneumatic compression controller with sequential calibrated gradient		2/15/2024	12/31/2999
	pressure	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0681	Non-pneumatic compression controller without calibrated gradient	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	pressure	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0682	Non-pneumatic sequential compression garment, full arm	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS,	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET	Medical Policy Criteria. Submit for Recommended		
	OR LESS	Clinical Review to avoid post-service review.		
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	eye protection, 4 foot panel	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	0.11.10000	10/04/00005
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	eye protection, 6 foot panel	Medical Policy Criteria. Submit for Recommended		
<b>-</b>		Clinical Review to avoid post-service review.	0.11.10000	10/04/00005
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	bulbs/lamps, timer and eye protection	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
F0700		Plan. Not subject to pre-service review.	545/000	40/04/0000
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
E0700		Policy (CPCP).	E (4 E 1000 A	40/04/0000
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
E0732	Cranial electrotherapy stimulation (ces) system, any type	Policy (CPCP). MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
E0732	Cranial electronierapy sumulation (ces) system, any type	Medical Policy Criteria. Submit for Recommended	2/13/2024	5/14/2024
		Clinical Review to avoid post-service review.		
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the		2/15/2024	12/31/2999
E0733		Medical Policy Criteria. Submit for Recommended	2/13/2024	12/31/2999
	trigeminal nerve	Clinical Review to avoid post-service review.		
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
E0734		Not subject to pre-service review. Check EIU policy,	5/15/2024	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist		5/15/2024	12/31/2999
L0734		Not subject to pre-service review. Check EIU policy,	5/15/2024	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
20734		Medical Policy Criteria. Submit for Recommended	2/13/2024	5/14/2024
		Clinical Review to avoid post-service review.		
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
L0733		Medical Policy Criteria. Submit for Recommended	2/13/2024	12/31/2333
		Clinical Review to avoid post-service review.		
E0736	Transcutaneous tibial nerve stimulator	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
20100		Medical Policy Criteria. Submit for Recommended	0/1/2024	12/01/2000
		Clinical Review to avoid post-service review.		
E0740	Non-implanted pelvic floor electrical stimulator, complete system	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	) 12/31/2999
		Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0740	Non-implanted pelvic floor electrical stimulator, complete system	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
20110		Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	applications	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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

E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,	5/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,	5/1/2020	12/01/2000
		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.	9/1/2020	12/31/2999
20040	STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO	Not subject to pre-service review. Check EIU policy,	0/1/2020	12/01/2000
	OTHER THAN MANDIBLE	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.	9/1/2020	12/31/2999
20010	STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO	Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
	OTHER THAN MANDIBLE	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0855	Cervical traction equipment not requiring additional stand or frame	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0855	Cervical traction equipment not requiring additional stand or frame	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service 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.	9/1/2020	12/31/2999
		Not subject to pre-service 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.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0860	Traction equipment, overdoor, cervical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0860	Traction equipment, overdoor, cervical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

E0890	Traction frame, attached to footboard, pelvic traction	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
20000		Not subject to pre-service review. Check EIU policy,		5/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
E0890	Traction frame, attached to footboard, pelvic traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
E0920	Fracture frame, attached to bed, includes weights	MP Criteria: Procedure/service reviewed against	11/1/2005		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
E0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against	11/1/2005		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	OTHER THAN KNEE	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	OTHER THAN KNEE	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
E0941	Gravity assisted traction device, any type	MP Criteria: Procedure/service reviewed against	11/1/2005		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
E0942	Cervical head harness/halter	EIU: Procedure/service not reimbursed by the Plan.		9/1/2020	12/31/2999
		Not subject to pre-service 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.	9/1/2020		12/31/2999
		Not subject to pre-service 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.		9/1/2020	12/31/2999
		Not subject to pre-service 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.	9/1/2020		12/31/2999
		Not subject to pre-service 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. Balken, 4	MP Criteria: Procedure/service reviewed against	11/1/2005		12/31/2999
	poster)	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
E0948	Fracture frame, attachments for complex cervical traction	MP Criteria: Procedure/service reviewed against	9/1/2020		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
E0950	Wheelchair accessory, tray, each	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

E0953	Wheelchair accessory, lateral thigh or knee support, any type including	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	fixed mounting hardware, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0954	Wheelchair accessory, foot box, any type, includes attachment and	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	mounting hardware, each foot	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	mounting hardware, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0969	Narrowing device, wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0981	Wheelchair accessory, seat upholstery, replacement only, each	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0982	Wheelchair accessory, back upholstery, replacement only, each	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. 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	6/1/2006	12/31/2999
	wheelchair to motorized wheelchair, joystick control	Medical Policy Criteria. 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	1/1/1950	12/31/2999
	wheelchair to motorized wheelchair, tiller control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0985	Wheelchair accessory, seat lift mechanism	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0986	Manual wheelchair accessory, push-rim activated power assist system	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	DRIVE, PAIR	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0992	Manual wheelchair accessory, solid seat insert	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1002	Wheelchair accessory, power seating system, tilt only	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1003	Wheelchair accessory, power seating system, recline only, without shear	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1004	Wheelchair accessory, power seating system, recline only, with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	mechanical shear reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E1005	Wheelchair accessory, power seatng system, recline only, with power	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1006	Wheelchair accessory, power seating system, combination tilt and recline,		6/1/2006	12/31/2999
	without shear reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1007	Wheelchair accessory, power seating system, combination tilt and recline,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	with mechanical shear reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1008	Wheelchair accessory, power seating system, combination tilt and recline,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	with power shear reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1009	Wheelchair accessory, addition to power seating system, mechanically	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	linked leg elevation system, including pushrod and leg rest, each	Medical Policy Criteria. Submit for Recommended	0, 1/2000	,
		Clinical Review to avoid post-service review.		
1010	Wheelchair accessory, addition to power seating system, power leg	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	elevation system, including leg rest, pair	Medical Policy Criteria. Submit for Recommended	5, ., 2000	
		Clinical Review to avoid post-service review.		
=1012	Wheelchair accessory, addition to power seating system, center mount	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	power elevating leg rest/platform, complete system, any type, each	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/01/2000
	power elevating leg resuplation, complete system, any type, each	Clinical Review to avoid post-service review.		
1028	Wheelchair accessory, manual swingaway, retractable or removable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
1020	mounting hardware for joystick, other control interface or positioning	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	accessorv	Clinical Review to avoid post-service review.		
E1083		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_ 1005		Medical Policy Criteria. Submit for Recommended	5/15/2014	12/3 1/2 3 3 3
	leg rest	Clinical Review to avoid post-service review.		
1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
1005	i lenii-wileelchait, ilkeu tuli lengtit annis, swilig away detachable toot rests	-	5/15/2014	12/3/12999
		Medical Policy Criteria. Submit for Recommended		
1087	High strength lightweight wheelchair, fixed full length arms, swing away	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
1007		5	3/13/2014	12/31/2999
	detachable elevating leg rests	Medical Policy Criteria. Submit for Recommended		
1170	Amputee wheelchair, fixed full length arms, swing away detachable	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
1170			3/15/2014	12/31/2999
	elevating legrests	Medical Policy Criteria. Submit for Recommended		
1171	A many stars with a stark sing five of full targets, suggest with such factors to an target	Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
	Amputee wheelchair, fixed full length arms, without footrests or legrest	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
-4470	A manuta a urba a labain data ababba anna (daali an full lanath) urithaut	Clinical Review to avoid post-service review.	2/45/2014	40/04/0000
1172	Amputee wheelchair, detachable arms (desk or full length) without	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	footrests or legrest	Medical Policy Criteria. Submit for Recommended		
- 1 1 0 0		Clinical Review to avoid post-service review.	0/45/0011	40/04/2022
E1180	Amputee wheelchair, detachable arms (desk or full length) swing away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	detachable footrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1195	Heavy duty wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	elevating legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E1200	Amputee wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	footrest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1220	Wheelchair; specially sized or constructed, (indicate brand name, model	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	number, if any) and justification	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1221	Wheelchair with fixed arm, footrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1225	Wheelchair accessory, manual semi-reclining back, (recline greater than	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	15 degrees, but less than 80 degrees), each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	80 degrees), each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1227	Special height arms for wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		12/01/2000
		Clinical Review to avoid post-service review.		
E1228	Special back height for wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
21220		Medical Policy Criteria. Submit for Recommended	0,10,2011	12/01/2000
		Clinical Review to avoid post-service review.		
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0,10,2011	12/01/2000
		Clinical Review to avoid post-service review.		
E1230	Power operated vehicle (three or four wheel nonhighway) specify brand	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
L 1200	name and model number	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1000	12/01/2000
		Clinical Review to avoid post-service review.		
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
21201	system	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	system	Clinical Review to avoid post-service review.		
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
L1200	SPECIFIED	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
		Clinical Review to avoid post-service review.		
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
L1200	footrest	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1000	12/01/2000
	lootiest	Clinical Review to avoid post-service review.		
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
L1290	Theavy duty wheelchair, fixed full length arms, elevating legrest	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1950	12/31/2999
		Clinical Review to avoid post-service review.		
E1300	Whirlpool, portable (overtub type)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	1/1/1000	12/31/2333
E1301	Whirlpool tub, walk-in, portable	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	5/15/2024	12/31/2333
E1310	Whidnest non-nortable (built in type)	Clinical Review to avoid post-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
E1310	Whirlpool, non-portable (built-in type)		1/1/1950	12/31/2999
E1355	Stand/rook	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
E1335	Stand/rack		1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

E1629	Tablo hemodialysis system for the billable dialysis service	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		/0 // 2000
		Clinical Review to avoid post-service review.		
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	······································	Not subject to pre-service review. Check EIU policy,		,
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service 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	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1701	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1702	Replacement measuring scales for jaw motion rehabilitation system, pkg.	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	Of 200	Plan. Not subject to pre-service review.		
E2120	Pulse generator system for tympanic treatment of inner ear	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	endolymphatic fluid	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than		6/1/2006	12/31/2999
	or equal to 20 inches and less than 24 inches	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2202	Manual wheelchair accessory, nonstandard seat frame width, 24-27	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	inches	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	than 22 inches	Medical Policy Criteria. Submit for Recommended		
<b>F</b> 0004		Clinical Review to avoid post-service review.	01410000	10/01/0000
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	inches	Medical Policy Criteria. Submit for Recommended		
E2206	Manual wheelchair accessory, wheel lock assembly, complete,	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
E2200	replacement only, each	Medical Policy Criteria. Submit for Recommended	1/1/2005	12/31/2999
	replacement only, each	Clinical Review to avoid post-service review.		
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	Non Covered: Procedure/service not covered by the	6/1/2006	12/31/2999
L2207	WHELECHAIR ACCESSORT, CROTCH AND CANE HOLDER, EACH	Plan. Not subject to pre-service review.	0/1/2000	12/31/2999
E2209	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
		Clinical Review to avoid post-service review.		
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	PROPULSION TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
-	PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	CASTER TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	size, replacement only, each	Medical Policy Criteria. Submit for Recommended	0, 1, 2000	,,
	Size, replacement only, caen	Clinical Review to avoid post-service review.		
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	(removable), any size, replacement only, each	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
	(ientovable), any size, replacement only, each	Clinical Review to avoid post-service review.		
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	integrated wheel, any size, replacement only, each	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	integrated wheel, any size, replacement only, each	Clinical Review to avoid post-service review.		
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	AND LOCK, COMPLETE, EACH	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
	AND LOOK, COMILETE, EACH	Clinical Review to avoid post-service review.		
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
22200		Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE		1/1/2009	12/31/2999
	(REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/01/2000
	HARDWARE	Clinical Review to avoid post-service review.		
E2291	Back, planar, for pediatric size wheelchair including fixed attaching	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	hardware	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/01/2000
	Inditiwale	Clinical Review to avoid post-service review.		
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	hardware	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/31/2333
	Indiuwale	,		
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
L2230	hardware	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/31/2999
	Indruware			
F2204	Cost contoured for podiatric size wheelsheir including five dettaching	Clinical Review to avoid post-service review.	1/1/2005	12/21/2000
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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

E2328	Power wheelchair accessory, head control or extremity control interface,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	electronic, proportional, including all related electronics and fixed	Medical Policy Criteria. Submit for Recommended		
	mounting hardware	Clinical Review to avoid post-service review.		
E2329	Power wheelchair accessory, head control interface, contact switch	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	mechanism, nonproportional, including all related electronics, mechanical	Medical Policy Criteria. Submit for Recommended		
	stop switch, mechanical direction change switch, head array, and fixed	Clinical Review to avoid post-service review.		
	mounting hardware			
E2330	Power wheelchair accessory, head control interface, proximity switch	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	mechanism, nonproportional, including all related electronics, mechanical	Medical Policy Criteria. Submit for Recommended		
	stop switch, mechanical direction change switch, head array, and fixed	Clinical Review to avoid post-service review.		
	mounting hardware	·		
E2331	Power wheelchair accessory, attendant control, proportional, including all	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	related electronics and fixed mounting hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	inches	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	inches	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2351	Power wheelchair accessory, electronic interface to operate speech	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	generating device using power wheelchair control interface	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
	ACID BATTERY, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID		1/1/2012	12/31/2999
	BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2360	Power wheelchair accessory, 22 nf non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2361	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	5	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	G. Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2364	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2365	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2366	Power wheelchair accessory, battery charger, single mode, for use with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	only one battery type, sealed or non-sealed, each	Medical Policy Criteria. Submit for Recommended		
	,, -, -, -, -, -, -, -, -, -, -, -, -, -,	Clinical Review to avoid post-service review.		
E2367	Power wheelchair accessory, battery charger, dual mode, for use with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	either battery type, sealed or non-sealed, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	ACID BATTERY, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2373	Power wheelchair accessory, hand or chin control interface, compact	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	remote joystick, proportional, including fixed mounting hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING	Medical Policy Criteria. Submit for Recommended		
	CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED	Clinical Review to avoid post-service review.		
	ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT			
	ONLY			
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND	Medical Policy Criteria. Submit for Recommended		
	MOUNTING HARDWARE, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	Medical Policy Criteria. Submit for Recommended		
	HARDWARE, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
E2377		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	Medical Policy Criteria. Submit for Recommended		
	HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	Clinical Review to avoid post-service review.		
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2500	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, less than or equal to 8 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		10/01/0000
E2502	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 8 minutes but less than or equal to 20 minutes	Medical Policy Criteria. Submit for Recommended		
<b>E</b> 0504	recording time	Clinical Review to avoid post-service review.	4/4/4050	10/01/0000
E2504	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 20 minutes but less than or equal to 40 minutes	Medical Policy Criteria. Submit for Recommended		
F0500	recording time	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
E2506	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 40 minutes recording time	Medical Policy Criteria. Submit for Recommended		
F0500		Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
E2508	Speech generating device, synthesized speech, requiring message	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	formulation by spelling and access by physical contact with the device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		l

E2510	Speech generating device, synthesized speech, permitting multiple	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	methods of message formulation and multiple methods of device access	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
E2511	Speech generating software program, for personal computer or personal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	digital assistant	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
E2512	Accessory for speech generating device, mounting system	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
22012	recessory for speech generaling device, meaning system	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1000	12/01/2000
		Clinical Review to avoid post-service review.		
E2599	Accessory for speech generating device, not otherwise classified	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		, 0 ., _ 0 0 0
		Clinical Review to avoid post-service review.		
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
22001	22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
LZOUZ	OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/01/2000
	ON GREATER, ANT DEF IT	Clinical Review to avoid post-service review.		
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
L2005	THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/31/2333
	THAN 22 INCHES, ANT DEFTH	Clinical Review to avoid post-service review.		
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
L2004		Medical Policy Criteria. Submit for Recommended	1/ 1/2003	12/3/12999
	INCHES OR GREATER, ANY DEPTH			
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
E2005			1/1/2005	12/31/2999
	INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
E2000		Ŭ	1/1/2005	12/31/2999
	GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
E2607		MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
F0000		Clinical Review to avoid post-service review.	4 14 10005	40/04/0000
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
F0000		Clinical Review to avoid post-service review.	4/4/0005	40/04/0000
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F0044		Clinical Review to avoid post-service review.	4 14 10005	40/04/0000
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING	Medical Policy Criteria. Submit for Recommended		
50040		Clinical Review to avoid post-service review.	4/4/0005	40/04/0000
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING	Medical Policy Criteria. Submit for Recommended		
	HARDWARE	Clinical Review to avoid post-service review.		
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE	Medical Policy Criteria. Submit for Recommended		
	MOUNTING HARDWARE	Clinical Review to avoid post-service review.		

E2614	POSITIONING WHEELCHAIR BACK CUSHION. POSTERIOR. WIDTH	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
	MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
2010		Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
	ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
_2010	LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT,	Medical Policy Criteria. Submit for Recommended	1/ 1/2005	12/31/2999
	INCLUDING ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
2017		Ŭ	1/1/2005	12/31/2999
	INCLUDING ANY TYPE MOUNTING HARDWARE	Medical Policy Criteria. Submit for Recommended		
-0000		Clinical Review to avoid post-service review.	1/1/2005	12/21/2000
2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	INCLUDING ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY	Medical Policy Criteria. Submit for Recommended		
	HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	WIDTH LESS THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	WIDTH 22 INCHES OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY	Medical Policy Criteria. Submit for Recommended		
	DEPTH	Clinical Review to avoid post-service review.		
2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY	Medical Policy Criteria. Submit for Recommended		
	DEPTH	Clinical Review to avoid post-service review.		
2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	Medical Policy Criteria. Submit for Recommended	0/10/2011	12/01/2000
	RANCHO TYPE	Clinical Review to avoid post-service review.		
2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	SOLLOKT ALLAGIED TO WHEELGHAIR, BALANCED, RECEINING	Clinical Review to avoid post-service review.		
2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
2029	SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
	ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL	Clinical Review to avoid post-service review.		
		Clinical Review to avoid post-service review.		
-2620	JOINTS) WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MD Criterio: Dreadure/activity and activity	3/15/2014	12/31/2999
2630		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT,	Medical Policy Criteria. Submit for Recommended		
	OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE	Clinical Review to avoid post-service review.		
	SUSPENSION SUPPORT		0// 5/00 : :	10/04/2000
2631		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	ELEVATING PROXIMAL ARM	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE	Medical Policy Criteria. Submit for Recommended	0, 10, 2011	12/01/2000
1	CONTROL	Clinical Review to avoid post-service review.		
E2633		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPINATOR	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E3000	Speech volume modulation system, any type, including all components	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E3000	Speech volume modulation system, any type, including all components	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	and accessories	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E3000	Speech volume modulation system, any type, including all components	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0176	Activity therapy, such as music, dance, art or play therapies not for	MP Criteria: Procedure/service reviewed against	7/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	health problems, per session (45 minutes or more)	Clinical Review to avoid post-service review.		
G0255	Current perception threshold/sensory nerve conduction test, (snct) per	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	limb, any nerve	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0255	Current perception threshold/sensory nerve conduction test, (snct) per	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	limb, any nerve	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided	Non Covered: Procedure/service not covered by the	1/1/2015	12/31/2999
1	lumbar decompression (pild) or placebo-control, performed in an	Plan. Not subject to pre-service review.		
1	approved coverage with evidence development (ced) clinical trial			
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and	Not subject to pre-service review. Check EIU policy,		
	venous statsis ulcers not demonstrating measurable signs of healing after	which is one of our Clinical Payment and Coding		
	30 days of conventional care, as part of a therapy plan of care	Policy (CPCP).		
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and	Not subject to pre-service review. Check EIU policy,		
	venous statsis ulcers not demonstrating measurable signs of healing after	which is one of our Clinical Payment and Coding		
	30 days of conventional care, as part of a therapy plan of care	Policy (CPCP).		
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	other than described in g0281	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	other than described in g0281	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0293	Noncovered surgical procedure(s) using conscious sedation, regional,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999

G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	only, in a medicare qualifying clinical trial, per day	Plan. Not subject to pre-service review.		
G0295	Electromagnetic therapy, to one or more areas, for wound care other than	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	described in g0329 or for other uses	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0295	Electromagnetic therapy, to one or more areas, for wound care other than	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	described in g0329 or for other uses	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis	Not subject to pre-service review. Check EIU policy,		
	ulcers not demonstrating measurable signs of healing after 30 days of	which is one of our Clinical Payment and Coding		
	conventional care as part of a therapy plan of care	Policy (CPCP).		
G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis	Not subject to pre-service review. Check EIU policy,		
	ulcers not demonstrating measurable signs of healing after 30 days of	which is one of our Clinical Payment and Coding		
	conventional care as part of a therapy plan of care	Policy (CPCP).		
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0416	Surgical pathology, gross and microscopic examinations, for prostate	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
	needle biopsy, any method	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g.,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	CMI, collagen scaffold, Menaflex)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g.,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	CMI, collagen scaffold, Menaflex)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0455	Preparation with instillation of fecal microbiota by any method, including	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	assessment of donor specimen	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0460	Autologous platelet rich plasma or other blood-derived product for non-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	diabetic chronic wounds/ulcers, including as applicable phlebotomy,	Not subject to pre-service review. Check EIU policy,		
	centrifugation or mixing, and all other preparatory procedures,	which is one of our Clinical Payment and Coding		
	administration and dressings, per treatment	Policy (CPCP).		

G0460	Autologous platelet rich plasma or other blood-derived product for non-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	diabetic chronic wounds/ulcers, including as applicable phlebotomy,	Not subject to pre-service review. Check EIU policy,		
	centrifugation or mixing, and all other preparatory procedures,	which is one of our Clinical Payment and Coding		
	administration and dressings, per treatment	Policy (CPCP).		
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
	diabetic chronic wounds/ulcers, using an FDA-cleared device for this	Not subject to pre-service review. Check EIU policy,		
	indication, (includes as applicable administration, dressings, phlebotomy,	which is one of our Clinical Payment and Coding		
	centrifugation or mixing, and all other preparatory procedures, per	Policy (CPCP).		
	treatment)	<b>y</b> ()		
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
	diabetic chronic wounds/ulcers, using an FDA-cleared device for this	Not subject to pre-service review. Check EIU policy,		
	indication, (includes as applicable administration, dressings, phlebotomy,	which is one of our Clinical Payment and Coding		
	centrifugation or mixing, and all other preparatory procedures, per	Policy (CPCP).		
	treatment)			
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services	MP Criteria: Procedure/service reviewed against	1/1/2018	9/14/2024
	for subdermal rod implant)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0518	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or	MP Criteria: Procedure/service reviewed against	1/1/2018	9/14/2024
	more (services for subdermal implants)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G2082	Office or other outpatient visit for the evaluation and management of an	MP Criteria: Procedure/service reviewed against	8/1/2021	12/31/2999
	established patient that requires the supervision of a physician or other	Medical Policy Criteria. Submit for Recommended		
	qualified health care professional and provision of up to 56 mg of	Clinical Review to avoid post-service review.		
	esketamine nasal self-administration, includes 2 hours post-			
	administration observation			
G2083	Office or other outpatient visit for the evaluation and management of an	MP Criteria: Procedure/service reviewed against	8/1/2021	12/31/2999
	established patient that requires the supervision of a physician or other	Medical Policy Criteria. Submit for Recommended		
	qualified health care professional and provision of greater than 56 mg	Clinical Review to avoid post-service review.		
	esketamine nasal self-administration, includes 2 hours post-			
	administration observation			
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	DOCUMENTATION AS NORMAL OR	Plan. Not subject to pre-service review.		
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	PERFORMED OR DOCUMENTED	Plan. Not subject to pre-service review.		
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	DOCUMENTATION OF THE	Plan. Not subject to pre-service review.		
G8399	Patient with documented results of a central dual-energy x-ray	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	absorptiometry (dxa) ever being performed	Plan. Not subject to pre-service review.		
G8400	Patient with central dual-energy x-ray absorptiometry (dxa) results not	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	documented, reason not given	Plan. Not subject to pre-service review.		
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	DOCUMENTED	Plan. Not subject to pre-service review.		
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8415	FOOTWEAR EVALUATION WAS NOT PERFORMED	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8416	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	CANDIDATE FOR FOOTWEAR	Plan. Not subject to pre-service review.		

G8417	Bmi is documented above normal parameters and a follow-up plan is	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	documented	Plan. Not subject to pre-service review.		
G8418	Bmi is documented below normal parameters and a follow-up plan is	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	documented	Plan. Not subject to pre-service review.		
G8419	Bmi documented outside normal parameters, no follow-up plan	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	documented, no reason given	Plan. Not subject to pre-service review.		
G8420	Bmi is documented within normal parameters and no follow-up plan is	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	required	Plan. Not subject to pre-service review.		
G8421	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8427	Eligible clinician attests to documenting in the medical record they	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	obtained, updated, or reviewed the patient's current medications	Plan. Not subject to pre-service review.		
G8428	Current list of medications not documented as obtained, updated, or	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	reviewed by the eligible clinician, reason not given	Plan. Not subject to pre-service review.		
G8430	Documentation of a medical reason(s) for not documenting, updating, or	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	reviewing the patient's current medications list (e.g., patient is in an urgent			
	or emergent medical situation)	, , ,		
G8431	Screening for depression is documented as being positive and a follow-up	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	plan is documented	Plan. Not subject to pre-service review.		
G8432	Depression screening not documented, reason not given	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8433	Screening for depression not completed, documented patient or medical	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	reason	Plan. Not subject to pre-service review.		
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00100		Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
G8451	Beta-blocker therapy for lvef <=40% not prescribed for reasons	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	documented by the clinician (e.g., low blood pressure, fluid overload,	Plan. Not subject to pre-service review.		
	asthma, patients recently treated with an intravenous positive inotropic			
	agent, allergy, intolerance, other medical reasons, patient declined, other			
	patient reasons)			
G8452	Beta-blocker therapy not prescribed	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00402		Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00400		Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00410	ANGIOTENSIN RECEPTOR BLOCKER	Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
G8474	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00111	blocker (arb) therapy not prescribed for reasons documented by the	Plan. Not subject to pre-service review.	1112000	12/01/2000
	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)			
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00470	blocker (arb) therapy not prescribed, reason not given	Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00470	and a diastolic measurement of < 90 mmhg	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2999
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00477			1/1/2006	12/31/2999
C0170	and/or a diastolic measurement of >=90 mmhg	Plan. Not subject to pre-service review.	1/1/2009	12/31/2999
G8478	Blood pressure measurement not performed or documented, reason not	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	given	Plan. Not subject to pre-service review.		

G8482	INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	RECEIVED	Plan. Not subject to pre-service review.		
G8483	Influenza immunization was not administered for reasons documented by	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	clinician (e.g., patient allergy or other medical reasons, patient declined or	Plan. Not subject to pre-service review.		
	other patient reasons, vaccine not available or other system reasons)			
G8484	Influenza immunization was not administered, reason not given	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
G8559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC	Plan. Not subject to pre-service review.		
	EVALUATION			
G8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	WITHIN THE PREVIOUS 90 DAYS	Plan. Not subject to pre-service review.		
G8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE	Plan. Not subject to pre-service review.		
	DRAINAGE MEASURE			
G8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00002	THE EAR WITHIN THE PREVIOUS 90 DAYS	Plan. Not subject to pre-service review.	1/ 1/2010	12/01/2000
G8563	Patient not referred to a physician (preferably a physician with training in	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00000	disorders of the ear) for an otologic evaluation, reason not given	Plan. Not subject to pre-service review.	1/ 1/2010	12/01/2000
G8564	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
66504	PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN	Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		
00505	OTOLOGIC EVALUATION, REASON NOT SPECIFIED) VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY	New Covered, Dresedure/service rest severed by the	4/4/2040	12/31/2999
G8565		Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00500	PROGRESSIVE HEARING LOSS	Plan. Not subject to pre-service review.	4/4/0040	10/01/0000
G8566	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING	Plan. Not subject to pre-service review.		
	LOSS MEASURE			
G8567	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	Plan. Not subject to pre-service review.		
G8568	Patient was not referred to a physician (preferably a physician with	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	training in disorders of the ear) for an otologic evaluation, reason not	Plan. Not subject to pre-service review.		
	given			
G8569	Prolonged postoperative intubation (> 24 hrs) required	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		
G8570	Prolonged postoperative intubation (> 24 hrs) not required	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		
G8575	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	DIALYSIS	Plan. Not subject to pre-service review.		
G8576	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		
G8577	Re-exploration required due to mediastinal bleeding with or without	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	tamponade, graft occlusion, valve dysfunction or other cardiac reason	Plan. Not subject to pre-service review.		
G8578	Re-exploration not required due to mediastinal bleeding with or without	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	tamponade, graft occlusion, valve dysfunction or other cardiac reason	Plan. Not subject to pre-service review.		
G8598	Aspirin or another antiplatelet therapy used	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		12/01/2000
G8599	Aspirin or another antiplatelet therapy not used, reason not given	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00000	Aspinit of another antiplatelet therapy not used, reason not given	Plan. Not subject to pre-service review.	1/1/2010	12/31/2333
G8600	Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
60000			1/1/2010	12/31/2999
	last known well	Plan. Not subject to pre-service review.		

G8601	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention)	Plan. Not subject to pre-service review.		
G8602	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G9050	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9051	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9053	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end- of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9056	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9058	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9059	Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9060	Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9061	Oncology; practice guidelines; patient's condition not addressed by	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	available guidelines (for use in a medicare-approved demonstration	Plan. Not subject to pre-service review.		
	project)			
G9062	Oncology; practice guidelines; management differs from guidelines for	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	other reason(s) not listed (for use in a medicare-approved demonstration	Plan. Not subject to pre-service review.		
	project)			
G9063	Oncology; disease status; limited to non-small cell lung cancer; extent of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	disease initially established as stage i (prior to neo-adjuvant therapy, if	Plan. Not subject to pre-service review.		
	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; extent of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	disease initially established as stage ii (prior to neo-adjuvant therapy, if	Plan. Not subject to pre-service review.		
	any) with no evidence of disease progression, recurrence, or metastases			
	(for use in a medicare-approved demonstration project)			10/04/0000
G9065		Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	disease initially established as stage iii a (prior to neo-adjuvant therapy, if	Plan. Not subject to pre-service review.		
	any) with no evidence of disease progression, recurrence, or metastases			
00000	(for use in a medicare-approved demonstration project)	New Occurrent Dream term to an iterate and the the	4/4/0000	40/04/0000
G9066	Oncology; disease status; limited to non-small cell lung cancer; stage iii b-		1/1/2006	12/31/2999
	iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a	Plan. Not subject to pre-service review.		
G9067	medicare-approved demonstration project) Oncology; disease status; limited to non-small cell lung cancer; extent of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9007	disease unknown, staging in progress, or not listed (for use in a medicare-		1/1/2006	12/31/2999
	approved demonstration project)	Plan. Not subject to pre-service review.		
G9068	Oncology; disease status; limited to small cell and combined small	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
09000	cell/non-small cell; extent of disease initially established as limited with no		1/ 1/2000	12/3/12999
	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 small cell and	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
03003	combined small cell/non-small cell; extensive stage at diagnosis,	Plan. Not subject to pre-service review.	1/ 1/2000	12/3/12999
	metastatic, locally recurrent, or progressive (for use in a medicare-			
	approved demonstration project)			
G9070	Oncology; disease status; small cell lung cancer, limited to small cell and	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	combined small cell/non-small; extent of disease unknown, staging in	Plan. Not subject to pre-service review.		
	progress, or not listed (for use in a medicare-approved demonstration			
	project)			
G9071	Oncology; disease status; invasive female breast cancer (does not	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as predominant cell	Plan. Not subject to pre-service review.		
	type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with	, , ,		
	no evidence of disease progression, recurrence, or metastases (for use in			
	a medicare-approved demonstration project)			
G9072	Oncology; disease status; invasive female breast cancer (does not	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as predominant cell	Plan. Not subject to pre-service review.		
	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 not	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no	Plan. Not subject to pre-service review.		
	evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)			
G9074	Oncology; disease status; invasive female breast cancer (does not	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as predominant cell	Plan. Not subject to pre-service review.		
	type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9075	Oncology; disease status; invasive female breast cancer (does not	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as predominant cell	Plan. Not subject to pre-service review.		
	type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use			
G9077	in a medicare-approved demonstration project) Oncology; disease status; prostate cancer, limited to adenocarcinoma as	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00011		Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
	diagnosis with no evidence of disease progression, recurrence, or	, ,		
	metastases (for use in a medicare-approved demonstration project)			
G9078	Oncology; disease status; prostate cancer, limited to adenocarcinoma as	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in			
	a medicare-approved demonstration project)			
G9079	Oncology; disease status; prostate cancer, limited to adenocarcinoma as	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no	Plan. Not subject to pre-service review.		
	evidence of disease progression, recurrence, or metastases (for use in a			
G9080	medicare-approved demonstration project) Oncology; disease status; prostate cancer, limited to adenocarcinoma;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00000	after initial treatment with rising psa or failure of psa decline (for use in a	Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
	medicare-approved demonstration project)			
G9083	Oncology; disease status; prostate cancer, limited to adenocarcinoma;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9084	Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; extent of disease initially	Plan. Not subject to pre-service review.		
	established as t1-3, n0, m0 with no evidence of disease progression,			
	recurrence, or metastases (for use in a medicare-approved demonstration			
G9085	project) Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00000	adenocarcinoma as predominant cell type; extent of disease initially	Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
	established as t4, n0, m0 with no evidence of disease progression,	, ,		
	recurrence, or metastases (for use in a medicare-approved demonstration			
00000	project)	New Coversed, Dressed werks wide net service it but the	4/4/2000	40/04/0000
G9086	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
	established as t1-4, n1-2, m0 with no evidence of disease progression,			
	recurrence, or metastases (for use in a medicare-approved demonstration			
	project)			

G9087	Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9088	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9089	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9090	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9091	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9092	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9093	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9094	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9095	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare- approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9099	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare- approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9100	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9101	Oncology; disease status; gastric cancer, limited to adenocarcinoma as	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9102	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare- approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9103	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9104	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9105	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9106	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9107	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9108	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9109	Oncology; disease status; head and neck cancer, limited to cancers of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
65105	oral cavity, pharynx and larynx with squamous cell as predominant cell	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2999
	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)			
G9110	Oncology; disease status; head and neck cancer, limited to cancers of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	oral cavity, pharynx and larynx with squamous cell as predominant cell	Plan. Not subject to pre-service review.		
	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)			
G9111	Oncology; disease status; head and neck cancer, limited to cancers of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	oral cavity, pharynx and larynx with squamous cell as predominant cell	Plan. Not subject to pre-service review.		
	type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use			
	in a medicare-approved demonstration project)			
G9112	Oncology; disease status; head and neck cancer, limited to cancers of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	oral cavity, pharynx and larynx with squamous cell as predominant cell	Plan. Not subject to pre-service review.		
	type; extent of disease unknown, staging in progress, or not listed (for use			
	in a medicare-approved demonstration project)			
G9113	Oncology; disease status; ovarian cancer, limited to epithelial cancer;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	pathologic stage ia-b (grade 1) without evidence of disease progression,	Plan. Not subject to pre-service review.		
	recurrence, or metastases (for use in a medicare-approved demonstration			
	project)			
G9114	Oncology; disease status; ovarian cancer, limited to epithelial cancer;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii;	Plan. Not subject to pre-service review.		
	without evidence of disease progression, recurrence, or metastases (for			
00445	use in a medicare-approved demonstration project)	New Osciera di Direcci di ma fa ambiene na fa conserva di busti a	4/4/0000	10/01/0000
G9115	Oncology; disease status; ovarian cancer, limited to epithelial cancer;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	pathologic stage iii-iv; without evidence of progression, recurrence, or	Plan. Not subject to pre-service review.		
G9116	metastases (for use in a medicare-approved demonstration project) Oncology; disease status; ovarian cancer, limited to epithelial cancer;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
03110	evidence of disease progression, or recurrence, and/or platinum	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2999
	resistance (for use in a medicare-approved demonstration project)			
G9117	Oncology; disease status; ovarian cancer, limited to epithelial cancer;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00111	extent of disease unknown, staging in progress, or not listed (for use in a	Plan. Not subject to pre-service review.	1/ 1/2000	12/01/2000
	medicare-approved demonstration project)			
G9123	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; chronic phase	Plan. Not subject to pre-service review.		
	not in hematologic, cytogenetic, or molecular remission (for use in a	, ,		
	medicare-approved demonstration project)			
G9124	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; accelerated	Plan. Not subject to pre-service review.		
	phase not in hematologic cytogenetic, or molecular remission (for use in a			
	medicare-approved demonstration project)			
G9125	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; blast phase not			
	in hematologic, cytogenetic, or molecular remission (for use in a medicare	4		
	approved demonstration project)			

G9126	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00.20	philadelphia chromosome positive and/or bcr-abl positive; in hematologic,			,
	cytogenetic, or molecular remission (for use in a medicare-approved			
	demonstration project)			
G9129	Oncology; disease status; limited to multiple myeloma, systemic disease;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	stage ii or higher (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9130	Oncology; disease status; limited to multiple myeloma, systemic disease;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	extent of disease unknown, staging in progress, or not listed (for use in a	Plan. Not subject to pre-service review.		
	medicare-approved demonstration project)			
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU);	Plan. Not subject to pre-service review.		
	ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF			
	DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED			
	(FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	)		
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
00102	ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-	Plan. Not subject to pre-service review.	11 11 2001	12/01/2000
	INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY			
	OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A			
	MEDICARE-APPROVED DEMONSTRATION PROJECT)			
G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL	Plan. Not subject to pre-service review.		
	METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-			
	APPROVED DEMONSTRATION PROJECT)			
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY		1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT	Plan. Not subject to pre-service review.		
	RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-			
	APPROVED DEMONSTRATION PROJECT)			
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY		1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT	Plan. Not subject to pre-service review.		
	REFRACTORY (FOR USE IN A MEDICARE-APPROVED			
00/00				10/04/0000
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA,	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A	Plan. Not subject to pre-service review.		
	SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-			
G9137	APPROVED DEMONSTRATION PROJECT) ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
G9137	CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE	Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
	IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)			
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
00100	CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE	Plan. Not subject to pre-service review.	1, 1/2001	12/01/2000
	NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-			
	RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A			
	MEDICARE-APPROVED DEMONSTRATION PROJECT)			
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE	Plan. Not subject to pre-service review.		
	AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN,	, , , , , , , , , , , , , , , , , , , ,		
	STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-			
	APPROVED DEMONSTRATION PROJECT)			

G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
00110	PATIENT STAY IN A CLINIC APPROVED FOR THE CMS	Plan. Not subject to pre-service review.	11 11 2000	12/01/2000
	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			
004.47	PERIOD UP TO 4 HOURS AFTER THE FIRST 4 HOURS		40/4/000	40/04/0000
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or	EIU: Procedure/service not reimbursed by the Plan.	12/1/202	0 12/31/2999
	continuous, by any means, guided by the results of measurements	Not subject to pre-service review. Check EIU policy,		
	for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arteria			
00117	venous or capillary glucose; and/or potassium concentration	Policy (CPCP).	10/1/2022	10/01/0000
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	continuous, by any means, guided by the results of measurements	Not subject to pre-service review. Check EIU policy,		
	for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arteria			
	venous or capillary glucose; and/or potassium concentration	Policy (CPCP).		
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0174	Injection, lecanemab-irmb, 1 mg	MP Criteria: Procedure/service reviewed against	9/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0177	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0178	Injection, aflibercept, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0179	Injection, brolucizumab-dbll, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0202	Injection, alemtuzumab, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2016	5/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	SPECIFIED	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

J0223	Injection, givosiran, 0.5 mg	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0224	Injection, lumasiran, 0.5 mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0225	Injection, vutrisiran, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2024
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
002.0	injection, remacerini, rinig	Medical Policy Criteria. Submit for Recommended	0,0	
		Clinical Review to avoid post-service review.		
J0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
00400	njoodon, bolddoopt, i ng	Medical Policy Criteria. Submit for Recommended	-, 1/2024	12/01/2000
		Clinical Review to avoid post-service review.		
J0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
50431		Medical Policy Criteria. Submit for Recommended	4/1/2022	12/31/2333
		Clinical Review to avoid post-service review.		
J0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
30317		0	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
J0565	Intertion herleterument 10 mm	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2018	3/14/2024
J0505	Injection, bezlotoxumab, 10 mg		1/1/2018	3/14/2024
		Medical Policy Criteria. Submit for Recommended		
10507		Clinical Review to avoid post-service review.	4/4/0040	0/04/0004
J0567	Injection, cerliponase alfa, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	3/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0584	Injection, burosumab-twza 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	4/30/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS	MP Criteria: Procedure/service reviewed against	1/1/1950	1/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	MP Criteria: Procedure/service reviewed against	1/1/2012	1/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0600	Injection, edetate calcium disodium, up to 1000 mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0717	Injection, certolizumab pegol, 1 mg (code may be used for medicare when		1/1/2014	6/14/2024
	drug administered under the direct supervision of a physician, not for use	Medical Policy Criteria. Submit for Recommended	1, 1/2014	0/17/2027
	when drug is self administered)	Clinical Review to avoid post-service review.		

J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv	MP Criteria: Procedure/service reviewed against	10/15/2023	3/14/2024
	pre-exposure prophylaxis (not for use as treatment for hiv)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0741	Injection, cabotegravir and rilpivirine, 2mg/3mg	MP Criteria: Procedure/service reviewed against	10/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	MG	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	<b>,</b> , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0888	Injectin, epoetin beta, 1 microgram, (for non esrd use)	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
	3 7 7 3 3 7 3	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
J1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
J1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed against	7/15/2020	12/31/2999
01000		Medical Policy Criteria. Submit for Recommended	1710/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
01004		Medical Policy Criteria. Submit for Recommended	2/10/2024	12/01/2000
		Clinical Review to avoid post-service review.		
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
01000	njoodon, ovindodnab dghb, onig	Medical Policy Criteria. Submit for Recommended	10/1/2021	12/01/2000
		Clinical Review to avoid post-service review.		
J1306	Injection, inclisiran, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
01000		Medical Policy Criteria. Submit for Recommended	111/2022	12/01/2000
		Clinical Review to avoid post-service review.		
J1325	Injection, epoprostenol, 0. 5 mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
01020		Medical Policy Criteria. Submit for Recommended	17 17 10000	12/01/2000
		Clinical Review to avoid post-service review.		
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	MP Criteria: Procedure/service reviewed against	5/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/ 1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	x 10^13 vector genomes	Medical Policy Criteria. Submit for Recommended	2/10/2024	12/31/2333
	x to to vector genomes			
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
51415	mjection, delandistrogene moxeparvovec-roki, per merapeutic dose		2/13/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	Clinical Review to avoid post-service review.		
Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	5		
Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	•		
	5		
Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Medical Policy Criteria. Submit for Recommended		
	-		
Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed against	6/1/2024	12/31/2999
	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	-		
Injection, immune globulin (asceniv), 500 mg		4/1/2021	12/31/2999
Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g.,		8/1/2023	12/31/2999
Injection, brexanolone, 1 mg		10/1/2020	12/31/2999
	,		
INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS		1/1/2006	3/14/2024
Injection, hydroxyprogesterone caproate, (makena), 10 mg		7/15/2023	12/31/2999
Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg		7/15/2023	12/31/2999
Injection, ibalizumab-uiyk, 10 mg		1/1/2019	3/31/2024
Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against	5/1/2023	12/31/2999
Injection, inebilizumab-cdon, 1 mg		3/1/2021	12/31/2999
INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
Injection, leuprolide acetate for depot suspension (fensolvi) 0.25 mg		7/1/2021	12/31/2999
	Medical Policy Criteria. Submit for Recommended		, 0 ., 2000
	Injection, viltolarsen, 10 mg         Injection, eteplirsen, 10 mg         Injection, golodirsen, 10 mg         Fecal microbiota, live - jslm, 1 ml         Injection, immune globulin (cutaquig), 100 mg         Injection, immune globulin (asceniv), 500 mg         Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg         Injection, brexanolone, 1 mg         INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.           Injection, viltolarsen, 10 mg         MP Criteria. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.           Injection, eteplirsen, 10 mg         MP Criteria. Procedure/service review.           Injection, golodirsen, 10 mg         MP Criteria. Procedure/service review.           Injection, immune globulin (cutaquig), 100 mg         MP Criteria. Submit for Recommended Clinical Review to avoid post-service review.           Injection, immune globulin (asceniv), 500 mg         MP Criteria. Procedure/service review.           Injection, immune globulin (parzyga), intravenous, non-tyophilized (e.g., Injection, immune globulin (parzyga), intravenous, non-tyophilized (e.g., Injection, brexanolone, 1 mg         MP Criteria. Submit for Recommended Clinical Review to avoid post-service review.           Injection, hydroxyprogesterone caproate, (makena), 10 mg         MP Criteria. Submit for Recommended Clinical Review to avoid post-service review.           Injection, Immune globulin (parzyga), intravenous, non-tyophilized (e.g., Injection, brexanolone, 1 mg         MP Criteria. Procedure/service review.           Injection, hydroxyprogesterone caproate, (make	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.         5/1/2021           Injection, vittolarsen, 10 mg         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.         1/1/2018           Injection, eteplinsen, 10 mg         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Bainst Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Bainst Medical Policy Criteria. Submit for

J1954	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM	MP Criteria: Procedure/service reviewed against	11/1/2006	5/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2329	Injection, ublituximab-xiiy, 1mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	injection, 25 mcg	Medical Policy Criteria. Submit for Recommended		
	, , , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
J2356	Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2502	Injection, pasireotide long acting, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2016	4/30/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2777	Injection, faricimab-svoa, 0.1 mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2782	Injection, avacincaptad pegol, 0.1 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2796	INJECTION, ROMIPLOSTIM, 10 MICROGRAMS	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3111	Injection, romosozumab-aggg, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		/0./_000
		Clinical Review to avoid post-service review.		
J3121	Injection, testosterone enanthate, 1mg	MP Criteria: Procedure/service reviewed against	1/1/2015	3/14/2024
		Medical Policy Criteria. Submit for Recommended	11 11 2010	0,11,2021
		Clinical Review to avoid post-service review.		
J3145	Injection, testosterone undecanoate, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2015	3/14/2024
10140	injection, testosterone undecanoate, i mg	Medical Policy Criteria. Submit for Recommended	1/ 1/2013	5/14/2024
		5		
J3241	Injection, teprotumumab-trbw, 10 mg	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
13241	injection, teprotumumab-trow, 10 mg	Ŭ	11/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
100.15		Clinical Review to avoid post-service review.	44/45/0000	F/04/0004
J3245	Injection, tildrakizumab, 1 mg	MP Criteria: Procedure/service reviewed against	11/15/2020	5/31/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3247	Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against	9/15/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
13393	Injection, betibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3396	INJECTION, VERTEPORFIN, 0.1 MG	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	1710/2001	12/01/2000
		Clinical Review to avoid post-service review.		
13398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
13390	Injection, voletigene nepalvovec-izyi, i billion vector genomes	•	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
13399	luisetien, en experimente et en en europeutei neu tracturent un te 5x40045	Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
13399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15	MP Criteria: Procedure/service reviewed against	//1/2020	12/31/2999
	vector genomes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	0// 5/000 /	10/04/00000
3401	Beremagene geperpavec-svdt for topical administration, containing	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3520	Edetate disodium, per 150 mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
13570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the	6/1/2015	12/31/2999
		Plan. Not subject to pre-service review.		
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	,, ··	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	6/15/2011		12/31/2999
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	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.	1/1/2016		12/31/2999
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020		12/31/2999
J7355	Injection, travoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024		12/31/2999
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2020	12/31/2999
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		12/31/2999
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2020	12/31/2999
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		12/31/2999
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2020	12/31/2999
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		12/31/2999
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/1/2020	12/31/2999
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020		12/31/2999

J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	) 12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	) 12/31/2999
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	) 12/31/2999
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	) 12/31/2999
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	0 12/31/2999
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
17000		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	40/4/0000		12/31/2999
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED		12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding Policy (CPCP).			
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25	Not subject to pre-service review. Check EIU policy,			
	MILLIGRAM	which is one of our Clinical Payment and Coding			
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
57054	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER	Not subject to pre-service review. Check EIU policy,			
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER	Not subject to pre-service review. Check EIU policy,			
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	Not subject to pre-service review. Check EIU policy,			
	MILLIGRAM	which is one of our Clinical Payment and Coding			
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
J7030	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
	MILLIGRAM	which is one of our Clinical Payment and Coding			
	MILLIGRAM	Policy (CPCP).			
J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
17000		Policy (CPCP).	40/4/0000		40/04/0000
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	) 12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding	, .,	
J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	0 12/31/2999
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	0 12/31/2999
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	) 12/31/2999
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
37030	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER		12/1/2020		12/31/2999
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7660		EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	MILLIGRAMS	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	DOSE FORM, PER 10 MILLIGRAMS	which is one of our Clinical Payment and Coding			
17070		Policy (CPCP).	40/4/0000		40/04/0000
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	DOSE FORM, PER 10 MILLIGRAMS	which is one of our Clinical Payment and Coding			
17070		Policy (CPCP).	10	14/0000	40/04/0000
J7676		EIU: Procedure/service not reimbursed by the Plan.	12	/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
12020		Policy (CPCP).	40/4/0000		40/04/0000
J7676		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

J7680	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7680	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7681	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding Policy (CPCP).			
J7681	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	Not subject to pre-service review. Check EIU policy,			
	FORM, PER MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER				
	MILLIGRAM	which is one of our Clinical Payment and Coding			
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
J7004	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER		12/1/2020		12/31/2999
	MILLIGRAM	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300	Not subject to pre-service review. Check EIU policy,		, ., _ 0 _ 0	12/01/2000
	MILLIGRAMS	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300	Not subject to pre-service review. Check EIU policy,			
	MILLIGRAMS	which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic	MP Criteria: Procedure/service reviewed against	8/1/2023		12/31/2999
	dose	Medical Policy Criteria. Submit for Recommended	1		
		Clinical Review to avoid post-service review.			
J9037	Injection, belantamab mafodontin-blmf, 0.5 mg	Non Covered: Procedure/service not covered by the	4/1/2024		12/31/2999
		Plan. Not subject to pre-service review.			
J9057	Injection, copanlisib, 1 mg	Non Covered: Procedure/service not covered by the	4/1/2024		12/31/2999
10005		Plan. Not subject to pre-service review.	0/1/00/10		10/01/0000
J9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the	9/1/2019		12/31/2999
		Plan. Not subject to pre-service review.			

J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the	4/1/2024	12/31/2999
		Plan. Not subject to pre-service review.		
J9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9333	Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9376	Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed against	4/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9381	Injection, teplizumab-mzwv, 5 mcg	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	_, ,, _ 0 0 0	,,
		Clinical Review to avoid post-service review.		
K0010	Standard - weight frame motorized/power wheelchair	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1/ 1/ 1000	12/01/2000
		Clinical Review to avoid post-service review.		
K0011	Standard - weight frame motorized/power wheelchair with programmable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	control parameters for speed adjustment, tremor dampening, acceleration	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2333
	control and braking	Clinical Review to avoid post-service review.		
K0012	Lightweight portable motorized/power wheelchair	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
K0012		Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
1/00/10	Custom Motorized/Power Wheelchair Base	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	7/1/2013	12/31/2999
K0013	Custom Motorized/Power wheelchair Base	5	7/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1/00/11		Clinical Review to avoid post-service review.	4/4/4050	10/01/0000
K0014	Other motorized/power wheelchair base	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0053	Elevating footrests, articulating (telescoping), each	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0056	Seat height less than 17 or equal to or greater than 21 for a high	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	strength, lightweight, or ultralightweight wheelchair	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0108	Wheelchair component or accessory, not otherwise specified	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0455	Infusion pump used for uninterrupted parenteral administration of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	medication, (e. G., epoprostenol or treprostinol)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0669	Seat/back custom; no dme pdac ver	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

K0743	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP,	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
	HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS			
		Clinical Review to avoid post-service review.		
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP,	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	INCHES	Clinical Review to avoid post-service review.		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
<b>K</b> 0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
<b>K</b> 0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
(0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
(0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		

K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601	Medical Policy Criteria. Submit for Recommended		
	POUNDS OR MORE	Clinical Review to avoid post-service review.		
(0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
(0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
(0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP			
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
(0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
(0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
(0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450			
	POUNDS	Clinical Review to avoid post-service review.		
<0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended		
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		
<0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	CAPACITY 601 POUNDS OR MORE	Clinical Review to avoid post-service review.		

K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP		10/1/2000	12/01/2000
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0842		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110042		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0843		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110040		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10040		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	300 POUNDS	Clinical Review to avoid post-service review.		
K0849		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110045		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	TATIENT WEIGHT CALACITY OF TO AND INCLUDING 5001 CONDS	Clinical Review to avoid post-service review.		
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	SEAT/BACK, FATIENT WEIGHT CAFACITE SUT TO 450 FOONDS	Clinical Review to avoid post-service review.		
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10001		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	FATIENT WEIGHT CAFACITE 301 TO 450 FOUNDS	Clinical Review to avoid post-service review.		
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10002	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	SEAT/BACK, FATIENT WEIGHT CAFACITY 451 TO 000 FOUNDS	Clinical Review to avoid post-service review.		
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	CHAIN, FATIENT WEIGHT CAFACITT, 451 TO 000 FOUNDS	Clinical Review to avoid post-service review.		
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110004		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0855		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP		10/1/2000	12/01/2000
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0857		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10007		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1.0000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0859		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450		10/1/2000	12/01/2000
	POUNDS	Clinical Review to avoid post-service review.		
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	1213112333
		Clinical Review to avoid post-service review.		
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		

K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP		10/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
K0862		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10002		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
K0863		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0864		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110004		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
		Clinical Review to avoid post-service review.		
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
NU000			10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1/0000		Clinical Review to avoid post-service review.	40/4/0000	10/01/0000
K0869		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
1/0070		Clinical Review to avoid post-service review.	10///0000	10/01/0000
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0871		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0877		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Medical Policy Criteria. Submit for Recommended		
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0880		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451	Medical Policy Criteria. Submit for Recommended		
	TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0884		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP			
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0885		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
K0890		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1/0090			10/1/2000	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP			
	TO AND INCLUDING 125 POUNDS	Clinical Review to avoid post-service review.		

K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006		12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP				
	TO AND INCLUDING 125 POUNDS	Clinical Review to avoid post-service review.			
K0899	Power mobile device; no dme pdac	MP Criteria: Procedure/service reviewed against	10/1/2006		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
K1004	Low frequency ultrasonic diathermy treatment device for home use	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
K1004		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic	EIU: Procedure/service not reimbursed by the Plan.		3/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
	without ankle joints any type, includes all components and accessories,	which is one of our Clinical Payment and Coding			
	motors, microprocessors, sensors	Policy (CPCP).			
K1007		EIU: Procedure/service not reimbursed by the Plan.	3/1/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
	motors, microprocessors, sensors	Policy (CPCP).			
K1027		MP Criteria: Procedure/service reviewed against	10/1/2021		7/31/2024
	fixed mechanical hinge, custom fabricated, includes fitting and adjustment				
		Clinical Review to avoid post-service review.			
K1030		MP Criteria: Procedure/service reviewed against	4/1/2022		12/31/2999
	cardiac contractility modulation generator, replacement only	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
K1036		EIU: Procedure/service not reimbursed by the Plan.		10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
1(4000		Policy (CPCP).	4.0/4/0000		40/04/0000
K1036		EIU: Procedure/service not reimbursed by the Plan.	10/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding Policy (CPCP).			
K1037		EIU: Procedure/service not reimbursed by the Plan.	1	10/1/2024	12/31/2999
1007		Not subject to pre-service review. Check EIU policy,		10/1/2024	12/31/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
K1037		EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,	10/1/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
K1037		MP Criteria: Procedure/service reviewed against	9/15/2024		9/30/2024
	airway collapsibility	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid	MP Criteria: Procedure/service reviewed against	4/1/2024		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
	fabricated	Clinical Review to avoid post-service review.			

L1834	Knee orthosis, without knee joint, rigid, custom-fabricated	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	custom fabricated	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR	Medical Policy Criteria. Submit for Recommended		
1	POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH			
	OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM			
	FABRICATED			
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR	Medical Policy Criteria. Submit for Recommended		
	POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH			
	OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM			
	FABRICATED			
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
L3060	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
L5610	Addition to lower extremity, endoskeletal system, above knee,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	hydracadence system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5611	Addition to lower extremity, endoskeletal system, above knee - knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with friction swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5613	Addition to lower extremity, endoskeletal system, above knee-knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with hydraulic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5614	Addition to lower extremity, exoskeletal system, above knee-knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	swing and stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5616	Addition to lower extremity, endoskeletal system, above knee, universal	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	multiplex system, friction swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5620	Addition to lower extremity, test socket, below knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5624	Addition to lower extremity, test socket, above knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5629	Addition to lower extremity, below knee, acrylic socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	socket	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5638	Addition to lower extremity, below knee, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5640	Addition to lower extremity, knee disarticulation, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5645	Addition to lower extremity, below knee, flexible inner socket, external	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20010	frame	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
	hanc	Clinical Review to avoid post-service review.		
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20040	socket	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	SUCKET	Clinical Review to avoid post-service review.		
L5647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20047	Addition to lower extremity, below knee suction socket	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20040	socket	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/31/2999
	SUCKEL	Clinical Review to avoid post-service review.		
L5651	Addition to lower extremity, above knee, flexible inner socket, external	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
L3031		Medical Policy Criteria. Submit for Recommended	0/1/2000	12/31/2999
	frame			
L5652	Addition to lower extremity, suction suspension, above knee or knee	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
L3032		•	0/1/2000	12/31/2999
	disarticulation socket	Medical Policy Criteria. Submit for Recommended		
L5670	Addition to lower extremity, below knee, molded supracondylar	Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L9070		MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	suspension ('pts' or similar)	Medical Policy Criteria. Submit for Recommended		
1 5070		Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1 5704		Clinical Review to avoid post-service review.	0/4/00000	40/04/0202
L5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
_5710	Addition, exoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	light material	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control (safety knee)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	swing phase control	Medical Policy Criteria. Submit for Recommended		
	51	Clinical Review to avoid post-service review.		
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	friction stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	(titanium, carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	light material	Medical Policy Criteria. Submit for Recommended	0, 1, 2000	,
		Clinical Review to avoid post-service review.		
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control (safety knee)	Medical Policy Criteria. Submit for Recommended	0, 1, 2000	,
		Clinical Review to avoid post-service review.		
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control, mechanical stance phase lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase lock	Medical Policy Criteria. Submit for Recommended		
	P	Clinical Review to avoid post-service review.		
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	friction stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control, with miniature high activity frame	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing,	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	and stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT	Medical Policy Criteria. Submit for Recommended		
	ADJUSTABILITY	Clinical Review to avoid post-service review.		
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE,	Medical Policy Criteria. Submit for Recommended		
	SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S),	Clinical Review to avoid post-service review.		
	ANY TYPE			
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE,	Medical Policy Criteria. Submit for Recommended		
	STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY	Clinical Review to avoid post-service review.		
	TYPE			
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	powered and programmable flexion/extension assist control, includes any	Medical Policy Criteria. Submit for Recommended		
	type motor(s)	Clinical Review to avoid post-service review.		

L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
20020	above knee, hip disarticulation, positional rotation unit, any type	Medical Policy Criteria. Submit for Recommended	0/10/2021	12/01/2000
		Clinical Review to avoid post-service review.		
_5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL,	Medical Policy Criteria. Submit for Recommended	0,2,,20,12	
	WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	Clinical Review to avoid post-service review.		
_5962	Addition, endoskeletal system, below knee, flexible protective outer	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	surface covering system	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	
	Sundoo oovoning System	Clinical Review to avoid post-service review.		
_5964	Addition, endoskeletal system, above knee, flexible protective outer	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	surface covering system	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	
	Sundoo oovoning System	Clinical Review to avoid post-service review.		
_5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	surface covering system	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
	surface covering system	Clinical Review to avoid post-service review.		
_5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active		4/15/2015	12/31/2999
	dorsiflexion feature	Medical Policy Criteria. Submit for Recommended	-1/10/2010	12/01/2000
		Clinical Review to avoid post-service review.		
_5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	any type motor(s)	Medical Policy Criteria. Submit for Recommended	1/ 1/2014	12/31/2999
	any type motor(s)	Clinical Review to avoid post-service review.		
.5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
.5970	All lower extremity prostneses, loot, external keel, sach loot	•	0/1/2000	12/31/2999
		Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
_5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
L3972	All lower extremity prostneses, root, nexible keel	•	0/1/2000	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
_5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
_5973			11/1/2019	12/31/2999
	CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR	Medical Policy Criteria. Submit for Recommended		
5074	FLEXION CONTROL, INCLUDES POWER SOURCE	Clinical Review to avoid post-service review.	0/4/0000	12/31/2999
_5974	All lower extremity prostheses, foot, single axis ankle/foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
5070		Clinical Review to avoid post-service review.	0/4/0000	10/01/0000
_5976		MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	or equal)	Medical Policy Criteria. Submit for Recommended		
5070		Clinical Review to avoid post-service review.	01410000	10/01/0000
_5978	All lower extremity prostheses, foot, multiaxial ankle/foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	0///0000	10/01/0000
_5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	one piece system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	01110005	10/01/2222
_5980	All lower extremity prostheses, flex foot system	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5981	All lower extremity prostheses, flex-walk system or equal	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		1

L5982	All exoskeletal lower extremity prostheses, axial rotation unit	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	without adjustability	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5987	All lower extremity prosthesis, shank foot system with vertical loading	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	pylon	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5991		EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L5991		EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	power, self-suspended, inner socket with removable forearm section,	Medical Policy Criteria. Submit for Recommended		
	electrodes and cables, two batteries, charger, myoelectric control of	Clinical Review to avoid post-service review.		
	terminal device, excludes terminal device(s)			
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	POWERED, ADDITIONAL SWITCH, ANY TYPE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		10/01/0000
L6621		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL	Medical Policy Criteria. Submit for Recommended		
1 0000		Clinical Review to avoid post-service review.	4/4/0040	10/01/0000
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED,	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
	INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR			
L6882	COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L0882		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	device	Medical Policy Criteria. Submit for Recommended		
L6920	Wrist disarticulation, outernal neuron calf successed of inner sealest	Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L0920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
	and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
L6925	Wrist disarticulation, external power, self-suspended inner socket,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0920	removable forearm shell, otto bock or equal electrodes, cables, two	Medical Policy Criteria. Submit for Recommended	4/1/2009	1213112333
	batteries and one charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6930	Below elbow, external power, self-suspended inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0330	forearm shell, otto bock or equal switch, cables, two batteries and one	Medical Policy Criteria. Submit for Recommended	4/1/2009	1213112333
	charger, switch control of terminal device	Clinical Review to avoid post-service review.		

L6935	Below elbow, external power, self-suspended inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	forearm shell, otto bock or equal electrodes, cables, two batteries and one	•		,,
	charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
_6940	Elbow disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	cables, two batteries and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
_6945	Elbow disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	humeral shell, outside locking hinges, forearm, otto bock or equal	Medical Policy Criteria. Submit for Recommended		,,
	electrodes, cables, two batteries and one charger, myoelectronic control	Clinical Review to avoid post-service review.		
	of terminal device			
_6950		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/01/2000
	two batteries and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
_6955	Above elbow, external power, molded inner socket, removable humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
10900	shell, internal locking elbow, forearm, otto bock or equal electrodes,	Medical Policy Criteria. Submit for Recommended	4/1/2003	12/31/2999
	cables, two batteries and one charger, myoelectronic control of terminal	Clinical Review to avoid post-service review.		
	device	Cillical Review to avoid post-service review.		
L6960	Shoulder disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
20900	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
	forearm, otto bock or equal switch, cables, two batteries and one charger,			
		Clinical Review to avoid post-service review.		
_6965	switch control of terminal device Shoulder disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
-0900		-	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal electrodes, cables, two batteries and one	Clinical Review to avoid post-service review.		
1 0070	charger, myoelectronic control of terminal device		4/4/0000	10/01/0000
L6970	Interscapular-thoracic, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal switch, cables, two batteries and one charger,	Clinical Review to avoid post-service review.		
	switch control of terminal device			
L6975	Interscapular-thoracic, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal electrodes, cables, two batteries and one	Clinical Review to avoid post-service review.		
	charger, myoelectronic control of terminal device			
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT		4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	PEDIATRIC	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	ADULT	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
-	PEDIATRIC	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L7170	Electronic elbow, hosmer or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
_7180	Electronic elbow, microprocessor sequential control of elbow and terminal		4/1/2009	12/31/2999	
	device	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
	CONTROL OF ELBOW AND TERMINAL DEVICE	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
	controlled	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7191	Electronic elbow, child, variety village or equal, myoelectronically	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
	controlled	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7259	Electronic wrist rotator, any type	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7360	Six volt battery, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7362	Battery charger, six volt, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended		,	
		Clinical Review to avoid post-service review.			
L7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
	·······;; · ····;	Medical Policy Criteria. Submit for Recommended		,	
		Clinical Review to avoid post-service review.			
L7366	Battery charger, twelve volt, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7367	Lithium ion battery, rechargeable, replacement	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999	
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe,	EIU: Procedure/service not reimbursed by the Plan.		5/15/2024 12/3	31/2999
	includes shipping and necessary supplies	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
_8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999	
	includes shipping and necessary supplies	Not subject to pre-service review. Check EIU policy,		12/01/2000	
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe,	MP Criteria: Procedure/service reviewed against	11/1/2019	5/14/2024
20000	includes shipping and necessary supplies	Medical Policy Criteria. Submit for Recommended	11/1/2010	0/14/2024
		Clinical Review to avoid post-service review.		
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
20001	COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES	Medical Policy Criteria. Submit for Recommended	11 11 2000	12/01/2000
	SHIPPING AND NECESSARY SUPPLIES	Clinical Review to avoid post-service review.		
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant,	EIU: Procedure/service not reimbursed by the Plan.	12/1/20	20 12/31/2999
20000	anal canal, 1 ml, includes shipping and necessary supplies	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	anal canal, 1 ml, includes shipping and necessary supplies	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe,	MP Criteria: Procedure/service reviewed against	5/1/2007	12/31/2999
	includes shipping and necessary supplies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
l	shipping and necessary supplies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8608	Miscellaneous external component, supply or accessory for use with the	EIU: Procedure/service not reimbursed by the Plan.	12/1/20	20 12/31/2999
	argus ii retinal prosthesis system	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L8608	Miscellaneous external component, supply or accessory for use with the	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	9/14/2024
	argus ii retinal prosthesis system	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
L8609	ARTIFICIAL CORNEA	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8678	Electrical stimulator supplies (external) for use with implantable	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	neurostimulator, per month	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8679	Implantable neurostimulator, pulse generator, any type	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8680	Implantable neurostimulator electrode, each	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE	Medical Policy Criteria. Submit for Recommended		
	GENERATOR, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
L8682	Implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against	9/19/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L8683	Radiofrequency transmitter (external) for use with implantable	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	neurostimulator radiofrequency receiver	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8685	Implantable neurostimulator pulse generator, single array, rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	includes extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8686	Implantable neurostimulator pulse generator, single array, non-	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	rechargeable, includes extension	Medical Policy Criteria. Submit for Recommended		
	5 ,	Clinical Review to avoid post-service review.		
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	includes extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8688	Implantable neurostimulator pulse generator, dual array, non-	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	rechargeable, includes extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT	Medical Policy Criteria. Submit for Recommended		
	ONLY	Clinical Review to avoid post-service review.		
L8694	Auditory osseointegrated device, transducer/actuator, replacement only,	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR	MP Criteria: Procedure/service reviewed against	9/19/2022	12/31/2999
	USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT	Medical Policy Criteria. Submit for Recommended		
	ONLY	Clinical Review to avoid post-service review.		
L8698	Miscellaneous component, supply or accessory for use with total artificial	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	heart system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8701	Powered upper extremity range of motion assist device, elbow, wrist,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	hand with single or double upright(s), includes microprocessor, sensors,	Medical Policy Criteria. Submit for Recommended		
	all components and accessories, custom fabricated	Clinical Review to avoid post-service review.		
L8702	Powered upper extremity range of motion assist device, elbow, wrist,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	hand, finger, single or double upright(s), includes microprocessor,	Medical Policy Criteria. Submit for Recommended		
	sensors, all components and accessories, custom fabricated	Clinical Review to avoid post-service review.		
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0100	Intragastric hypothermia using gastric freezing	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
M0240	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	imdevimab includes infusion or injection, and post administration	Not subject to pre-service review. Check EIU policy,		
	monitoring, subsequent repeat doses	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

M0240	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
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).	6/1/202	12/31/2999
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/202	12/31/2999
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/202	12/31/2999
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/202	12/31/2999
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency	which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/202	12/31/2999
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999

M0300	Iv chelation therapy (chemical endarterectomy)	MP Criteria: Procedure/service reviewed against	1/1/1950		12/31/2999
	in onolation thorapy (onolinear ondartorootomy)	Medical Policy Criteria. Submit for Recommended	1, 1, 1000		12/01/2000
		Clinical Review to avoid post-service review.			
M0301	Fabric wrapping of abdominal aneurysm	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
		Plan. Not subject to pre-service review.			12/01/2000
P2029	Congo red, blood	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
1 2020		Plan. Not subject to pre-service review.			12/01/2000
P2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed against	9/24/2012		12/31/2999
	· ····· ······························	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
P9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
P9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
P9603	Travel allowance one way in connection with medically necessary	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
	laboratory specimen collection drawn from home bound or nursing home	Plan. Not subject to pre-service review.			
	bound patient; prorated miles actually travelled				
P9604	Travel allowance one way in connection with medically necessary	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
	laboratory specimen collection drawn from home bound or nursing home	Plan. Not subject to pre-service review.			
	bound patient; prorated trip charge.				
Q0035	Cardiokymography	Non Covered: Procedure/service not covered by the	1/1/1950		12/31/2999
		Plan. Not subject to pre-service review.			
Q0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed by the Plan.		6/1/2023	12/31/2999
		Not subject to pre-service 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.	6/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan.		6/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan.		6/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP)			
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q0482	Microprocessor control unit for use with electric/pneumatic combination	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	ventricular assist device, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0485	Monitor control cable for use with electric ventricular assist device,	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
1	ventricular assist device, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0490	Emergency power source for use with electric ventricular assist device,	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0492	Emergency power supply cable for use with electric ventricular assist	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	device, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0494	Emergency hand pump for use with electric or electric/pneumatic	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	ventricular assist device, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0504	Power adapter for pneumatic ventricular assist device, replacement only,	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	vehicle type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0510	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	DRUG(S), FIRST MONTH FOLLOWING transPLANT	Plan. Not subject to pre-service review.		
Q0511	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST	Plan. Not subject to pre-service review.		
	PRESCRIPTION IN A 30-DAY PERIOD			
Q0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	immunosuppressive drug(s); for a subsequent prescription in a 30-day	Plan. Not subject to pre-service review.	1/ 1/ 2000	12/01/2000
	period			
Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved	Non Covered: Procedure/service not covered by the	1/2/2024	12/31/2999
00010	prescription oral drug, per 30-days	Plan. Not subject to pre-service review.	17272024	12/01/2000
Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved	Non Covered: Procedure/service not covered by the	1/2/2024	12/31/2999
	prescription oral drug, per 60-days	Plan. Not subject to pre-service review.		12/01/2000
Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved	Non Covered: Procedure/service not covered by the	1/2/2024	12/31/2999
	prescription oral drug, per 90-days	Plan. Not subject to pre-service review.	1/2/2024	12/01/2999
Q2026	INJECTION, RADIESSE, 0.1 ML	MP Criteria: Procedure/service reviewed against	8/15/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/13/2013	1213112333
		Clinical Review to avoid post-service review.		

Q2028	Injection, sculptra, 0.5 mg	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car	MP Criteria: Procedure/service reviewed against	4/1/2018	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including	MP Criteria: Procedure/service reviewed against	7/1/2011	12/31/2999
alo il	leukapheresis and dose preparation procedures, per therapeutic dose	Medical Policy Criteria. Submit for Recommended	17 11 2011	12/01/2000
	leukapheresis and dose preparation procedures, per therapedite dose	Clinical Review to avoid post-service review.		
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg		4/1/2024	12/31/2999
Q2043		Plan. Not subject to pre-service review.	4/1/2024	12/31/2333
Q2052	Services, supplies, and accessories used in the home for the	Non Covered: Procedure/service not covered by the	4/1/2014	12/31/2999
Q2002			4/1/2014	12/31/2999
Q2053	administration of intravenous immune globulin (ivig) Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car	Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
Q2055			4/1/2021	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
00054	procedures, per therapeutic dose	Clinical Review to avoid post-service review.	10/1/0001	10/01/0000
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	antigen (bcma) directed car-positive t cells, including leukapheresis and	Medical Policy Criteria. Submit for Recommended		
	dose preparation procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	antigen (bcma) directed car-positive t cells, including leukapheresis and	Medical Policy Criteria. Submit for Recommended		
	dose preparation procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Plan. Not subject to pre-service review.		
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q TIVE		Medical Policy Criteria. Submit for Recommended	11,10,2020	12/01/2000
		Clinical Review to avoid post-service review.		
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
Q4105	OASIS BONN WATNIN, I EN SQUARE CENTIMETER	Not subject to pre-service review. Check EIU policy,	3/13/2021	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
Q4103	UASIS DURIN MATRIX, PER SQUARE CENTIMETER		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	SQUARE CENTIMETER	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	11/15/2020		12/31/2999
0.4.4.5		Clinical Review to avoid post-service review.			10/01/0000
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4121	THERASKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	6/30/2024
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4121	THERASKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		6/30/2024
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4121	THERASKIN, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	7/1/2024		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square	MP Criteria: Procedure/service reviewed against	10/15/2021		12/31/2999
	centimeter	Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4123	ALLOSKIN RT. PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
Q+120		Not subject to pre-service review. Check EIU policy,	5/15/2021	12/01/2000
		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.	5/15/20	21 12/31/2999
	CENTIMETER	Not subject to pre-service 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.	5/15/2021	12/31/2999
	CENTIMETER	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/20	21 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/20	21 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/20	21 12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
0.4.407		Policy (CPCP).	5// 5/000/	10/04/0000
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
Q4128	Flex hd, or allopatch hd, per square centimeter	Policy (CPCP). MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q4120	Flex hd, of allopatch hd, per square centimeter	Medical Policy Criteria. Submit for Recommended	11/15/2020	12/31/2999
		Clinical Review to avoid post-service review.		
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/20	21 12/31/2999
Q4150	STRATICE IN, FER SQUARE CENTIMETER	Not subject to pre-service review. Check EIU policy,	5/15/20	21 12/31/2999
		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.	5/15/2021	12/31/2999
Q-1100		Not subject to pre-service review. Check EIU policy,	0,10/2021	1210112000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
Q.TIU2	כרמות סטוט מות שומותף סטוט, אבו שעעמוב טבוונווופנט	Medical Policy Criteria. Submit for Recommended	0,10/2021	1210112000
		Clinical Review to avoid post-service review.		
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Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4134	Hmatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4134	Hmatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4135	Mediskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4135	Mediskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4136	Ez-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4136	Ez-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4407		Policy (CPCP).	-	40/4/0000	10/04/0000
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
Q4137	Amnicovael amnicovael plus or biodovael per orwers continuetor	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		7/31/2024
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter		12/1/2020		//31/2024
		Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	MP Criteria: Procedure/service reviewed against	8/1/2024		12/31/2999
Q4137	Annioexcel, annioexcel plus of biodexcel, pel square centimeter	Medical Policy Criteria. Submit for Recommended	0/1/2024		12/31/2999
		Clinical Review to avoid post-service review.			
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
QTIOU	biodicitos di yitox, por square continteter	Not subject to pre-service review. Check EIU policy,		12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
	· ····································	Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4146	Tensix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4146	Tensix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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 square	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
	centimeter	Not subject to pre-service 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 square	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
	centimeter	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4151	Amnioband or guardian, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.	1		
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
arroo	Bolinaroot and plantoot, por oqualo continetor	Not subject to pre-service review. Check EIU policy,		12/ 1/2020	12/01/2000
		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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed against	2/1/2022		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	1	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4168	Amnioband, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
~		Not subject to pre-service review. Check EIU policy,		12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,	12/1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/1/2021	12/31/2999
Q4175	Milodenn, per square centimeter	Not subject to pre-service review. Check EIU policy,		4/1/2021	12/31/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2021		12/31/2999
Q4175	Milodelin, per square centimeter	Not subject to pre-service review. Check EIU policy,	4/1/2021		12/31/2999
		which is one of our Clinical Payment and Coding			
04470		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		40/4/0000	40/04/0000
Q4176	Neopatch or therion, per square centimeter			12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4470		Policy (CPCP).	4.0/4/0000		40/04/0000
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
G I I OU		Not subject to pre-service review. Check EIU policy,		12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
Q4180	Revita, per square centimeter		12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
<b>.</b>		Policy (CPCP).			
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
arior		Not subject to pre-service review. Check EIU policy,		12/ 1/2020	12/01/2000
		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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,	12/1/2020		12/01/2000
		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.	1	12/1/2020	12/31/2999
Q4100	Cenesta nowable annion (25 mg per cc), per 0.5 cc			12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4405		Policy (CPCP).	10/1/2025		10/01/0000
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended	1		
		Clinical Review to avoid post-service review.			
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4404		Policy (CPCP).	10/1/0000		40/04/0000
Q4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
Q4192	Destavisin 4 se	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
Q4192	Restorigin, 1 cc	•		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
Q4192	Restorigin, 1 cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
Q4192		Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
		which is one of our Clinical Payment and Coding			
04102	Coll o dorm por oquare continuetor	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		5/15/0004	10/01/0000
Q4193	Coll-e-derm, per square centimeter			5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
	·····,,	Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		0, 10, 202 .	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,	0, 10, 2021		12/01/2000
		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.		5/15/2021	12/31/2999
arroo		Not subject to pre-service review. Check EIU policy,		0,10,2021	12/01/2000
		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.	5/15/2021		12/31/2999
arroo		Not subject to pre-service review. Check EIU policy,	0,10,2021		12/01/2000
		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.		12/1/2020	12/31/2999
	· ····································	Not subject to pre-service 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.	12/1/2020		12/31/2999
	· ····································	Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.	1	4/15/2022	12/31/2999
<u> </u>		Not subject to pre-service review. Check EIU policy,		., 10,2022	12/01/2000
		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.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
ao.		Not subject to pre-service review. Check EIU policy,		12/ 1/2020	,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	marini, por oquaro committori	Not subject to pre-service review. Check EIU policy,	12/ 1/2020		12/01/2000
		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.		5/15/2021	12/31/2999
G 1202	1.00,000, 100	Not subject to pre-service review. Check EIU policy,		0/10/2021	12/01/2000
		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.	5/15/2021		12/31/2999
Q-LUL	101000 (2.09,00), 100	Not subject to pre-service review. Check EIU policy,	0,10,2021		12/01/2000
		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.		5/15/2021	12/31/2999
a 1200	Bonna giao, por equare continuetor	Not subject to pre-service review. Check EIU policy,		0/10/2021	12/01/2000
		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.	5/15/2021		12/31/2999
a 1200	Bonna giao, por equare continuetor	Not subject to pre-service review. Check EIU policy,	0,10,2021		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
ao.		Not subject to pre-service review. Check EIU policy,		12/ 1/2020	,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	Monistane gran or monistane wrap, per square centimeter	Not subject to pre-service review. Check EIU policy,		12/1/2020	12/01/2009
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	6/30/2024
		Not subject to pre-service 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.	12/1/2020		6/30/2024
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
04210	Nooni, o.o mg	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/01/2000
		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.		12/1/2020	12/31/2999
Q4214	Cellesta colu, per square centimeter	Not subject to pre-service review. Check EIU policy,		12/1/2020	12/31/2999
		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.	12/1/2020		12/31/2999
Q4214	Cellesta coru, per square centimeter	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
		which is one of our Clinical Payment and Coding			
04045	Availati ambient en evaleti en a. O d nen	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.		40/4/0000	40/04/0000
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg			12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.001-		Policy (CPCP).	10/1/0000		10/01/0000
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or			12/1/2020	12/31/2999
	BioWound Xplus, per square centimeter	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or		12/1/2020		12/31/2999
	BioWound Xplus, per square centimeter	Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		5/15/2021	12/31/2999
		Not subject to pre-service 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.	5/15/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022		12/31/2999
		Not subject to pre-service 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.		8/1/2022	12/31/2999
		Not subject to pre-service 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.	8/1/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4226				10/1/2024	12/31/2999
	centimeter	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4000		Policy (CPCP).	10/1/0001		10/01/0000
Q4226		EIU: Procedure/service not reimbursed by the Plan.	10/1/2024		12/31/2999
	centimeter	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4226	MyOwn skin, includes harvesting and preparation procedures, per square	MP Criteria: Procedure/service reviewed against	7/1/2024		9/30/2024
Q7220	centimeter	Medical Policy Criteria. Submit for Recommended	1/1/2024		5/50/2024
	oon amotor	Clinical Review to avoid post-service review.			
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4000		Policy (CPCP).	4.0/4/0000		40/04/0000
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
d 1200		Not subject to pre-service review. Check EIU policy,		12, 1,2020	12/01/2000
		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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.400.4		Policy (CPCP).	10/1/00000		10/01/0000
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.			
	Not subject to pre-service review. Check EIU policy,		12/1/2020	12/31/2999
Comlex, per square continutor	EILI: Procedure/convice not reimburged by the Plan	12/1/2020		12/31/2999
		12/1/2020		12/31/2999
			40/4/0000	40/04/0000
Surfactor or hudyn, per 0.5 cc			12/1/2020	12/31/2999
		40/4/0000		40/04/0000
Suffactor or hudyn, per 0.5 cc		12/1/2020		12/31/2999
		_		
Xcellerate, per square centimeter			12/1/2020	12/31/2999
	which is one of our Clinical Payment and Coding			
Xcellerate, per square centimeter		12/1/2020		12/31/2999
Amniorepair or altiply, per square centimeter			12/1/2020	12/31/2999
Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	Not subject to pre-service review. Check EIU policy,			
	which is one of our Clinical Payment and Coding			
	Policy (CPCP).			
Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
	Not subject to pre-service review. Check EIU policy,			
	which is one of our Clinical Payment and Coding			
	Policy (CPCP).			
Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
	Not subject to pre-service review. Check EIU policy,			
Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
Crvo-cord per square centimeter	FIU: Procedure/service not reimbursed by the Plan	12/1/2020		12/31/2999
		.2, 1,2020		
	Carepatch, per square centimeter	Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Surfactor or nudyn, per 0.5 cc         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Surfactor or nudyn, per 0.5 cc         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Xcellerate, per square centimeter         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Xcellerate, per square centimeter         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Xcellerate, per square centimeter         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Amniorepair or altiply, per square centimeter         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Carepatch, per square centimeter         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           Carepatch, per square centimeter         EIU: Procedure/service not reimbursed	Policy (CPCP),         Presence of the second restrict on t	Paller (CPCP).         Paller (CPCP).           Corplex, per square centimeter         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Surfactor or nudyn, per 0.5 cc         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Surfactor or nudyn, per 0.5 cc         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Xcellerate, per square centimeter         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Xcellerate, per square centimeter         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Amniorepair or altiply, per square centimeter         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020           Amniorepair or altiply, per square centimeter         EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy. which is one of our Clinical Payment and Coding Policy (CPCP).         12/1/2020 </td

Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		.,	, 0 ., _ 0 00
		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.	7/1/2022		12/31/2999
4.200		Not subject to pre-service 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.		12/1/2020	12/31/2999
a		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,	, .,_0_0		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4240	Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4240	Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4241	Polycyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4241	Polycyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	3/31/2024
		Not subject to pre-service 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.	12/1/2020		3/31/2024
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
Q424J	Ammolexi, per cc	Not subject to pre-service review. Check EIU policy,	12/1/2020		12/31/2999
		which is one of our Clinical Payment and Coding			
0.40.40		Policy (CPCP).		10/1/0000	40/04/0000
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan.		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
<b>•</b> • • • •		Policy (CPCP).			
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
		Not subject to pre-service 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.		12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020		12/31/2999
	5,11	Not subject to pre-service 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.		3/1/2021	12/31/2999
a.=		Not subject to pre-service review. Check EIU policy,		0/ 1/2021	12/01/2000
		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.	3/1/2021		12/31/2999
Q1210		Not subject to pre-service review. Check EIU policy,	0/ 1/2021		12/01/2000
		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.		3/1/2021	12/31/2999
Q+200	Annioanip-inp, per square centimeter	Not subject to pre-service review. Check EIU policy,		5/1/2021	12/31/2999
		which is one of our Clinical Payment and Coding			
0.4050		Policy (CPCP).	0/4/0004		40/04/0000
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	3/1/2021		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
Q7201		Not subject to pre-service review. Check EIU policy,		-+/ 10/2022	12/51/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
04201		Not subject to pre-service review. Check EIU policy,	4/13/2022		12/31/2999
		which is one of our Clinical Payment and Coding			
0.4050		Policy (CPCP).		4/45/0000	40/04/0000
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4050		Policy (CPCP).			10/01/0000
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022		12/31/2999
		Not subject to pre-service 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.		3/1/2021	12/31/2999
		Not subject to pre-service 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.	3/1/2021		12/31/2999
		Not subject to pre-service 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.		3/1/2021	12/31/2999
a.200		Not subject to pre-service review. Check EIU policy,		0/ 1/202	
		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.	3/1/2021		12/31/2999
d 1200	rtoguara, for topicar dee enty, per equare continioter	Not subject to pre-service review. Check EIU policy,	0, 1,2021		12/01/2000
		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.		8/1/2022	12/31/2999
Q7200	inig-complete, per square centimeter	Not subject to pre-service review. Check EIU policy,		0/1/2022	12/31/2999
		which is one of our Clinical Payment and Coding			
04050		Policy (CPCP).	0/4/0000		40/04/0000
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022		12/31/2999
		Not subject to pre-service 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.		8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		0, 1, 2022	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022		12/31/2999
Q 1201		Not subject to pre-service review. Check EIU policy,	0, 1, 2022		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		8/1/2022	12/31/2999
Q7200		Not subject to pre-service review. Check EIU policy,		0/1/2022	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022		12/31/2999
Q7200		Not subject to pre-service review. Check EIU policy,	0/1/2022		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		17 17 2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
a		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023		12/31/2999
		Not subject to pre-service 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.		1/1/2023	12/31/2999
		Not subject to pre-service 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.	1/1/2023		12/31/2999
		Not subject to pre-service 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.		1/1/2023	12/31/2999
		Not subject to pre-service 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.	1/1/2023		12/31/2999
		Not subject to pre-service 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.		1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		1/ 1/2020	12/01/2000
		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.	1/1/2023		12/31/2999
Q-1200		Not subject to pre-service review. Check EIU policy,	1/ 1/2020		12/01/2000
		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.	-	1/1/2023	12/31/2999
04204	obooon monistane, per oquare continuer	Not subject to pre-service review. Check EIU policy,		1/ 1/2020	12/01/2000
		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.	1/1/2023		12/31/2999
Q+20+	obooon monistane, per oquare continuer	Not subject to pre-service review. Check EIU policy,	1/ 1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
G 1200		Not subject to pre-service review. Check EIU policy,		0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
a		Not subject to pre-service review. Check EIU policy,	0/ 1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
	······································	Not subject to pre-service review. Check EIU policy,			,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
		Not subject to pre-service 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.		9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		0/ 1/2020	12/01/2000
		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.	9/1/2023		12/31/2999
Q-1200		Not subject to pre-service review. Check EIU policy,	0/1/2020		12/01/2000
		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.		9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		5/1/2025	12/01/2000
		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.	9/1/2023		12/31/2999
Q4210	Complete si, per square centimeter	Not subject to pre-service review. Check EIU policy,	3/1/2023		12/31/2333
		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.	-	9/1/2023	12/31/2999
Q4271	Complete It, per square centimeter	Not subject to pre-service review. Check EIU policy,		9/1/2023	12/31/2999
		which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4271	Complete ft. per equere contineter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023		12/31/2999
Q4271	Complete ft, per square centimeter		9/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4070		Policy (CPCP).		40/4/0000	10/04/0000
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4070		Policy (CPCP).	4.0.14.10.0.0.0		10/01/0000
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
	, <b>_</b> , <b>_</b> , <b>_</b>	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		12/31/2999
d 1210		Not subject to pre-service review. Check EIU policy,	12/ 1/2020		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
Q4210		Not subject to pre-service review. Check EIU policy,		12/1/2025	12/51/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		12/31/2999
Q4270	Onon, per square centimeter	Not subject to pre-service review. Check EIU policy,	12/1/2023		12/31/2999
		which is one of our Clinical Payment and Coding			
0.4077		Policy (CPCP).		40/4/0000	0/00/0004
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	6/30/2024
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4077		Policy (CPCP).	10/1/0000		0/00/000/
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023		6/30/2024
		Not subject to pre-service 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.		12/1/2023	12/31/2999
		Not subject to pre-service 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.	12/1/2023		12/31/2999
		Not subject to pre-service 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.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
		Not subject to pre-service 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	3/15/2024		6/30/2024
		Medical Policy Criteria. 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.		12/1/2023	12/31/2999
		Not subject to pre-service 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.	12/1/2023		12/31/2999
		Not subject to pre-service 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.		12/1/2023	12/31/2999
		Not subject to pre-service 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.	12/1/2023		12/31/2999
		Not subject to pre-service 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.		12/1/2023	12/31/2999
		Not subject to pre-service 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.	12/1/2023		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4283	Biovance tri-layer or biovance 3l, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2023		12/31/2999
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		12/1/2023	12/31/2999
		Not subject to pre-service 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.	12/1/2023		12/31/2999
		Not subject to pre-service 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.		10/1/2023	12/31/2999
		Not subject to pre-service 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.	10/1/2023		12/31/2999
		Not subject to pre-service 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.		10/1/2023	12/31/2999
		Not subject to pre-service 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.	10/1/2023		12/31/2999
		Not subject to pre-service 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.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		.,	, 0 ., 2000
		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.	7/1/2024		12/31/2999
Q+Z01		Not subject to pre-service review. Check EIU policy,	11112024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4287	Dermabind dl, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
Q4201	Dermability di, per square centimeter	Medical Policy Criteria. Submit for Recommended	5/15/2024		0/30/2024
		Clinical Review to avoid post-service review.			
Q4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
Q4200	Dermability on, per square centimeter	Not subject to pre-service review. Check EIU policy,		1/1/2024	12/31/2999
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
Q4200	Dermabilità ch, per square centimeter	Not subject to pre-service review. Check EIU policy,	7/1/2024		12/31/2999
		which is one of our Clinical Payment and Coding			
0.4000		Policy (CPCP).	0/45/0004		0/00/0004
Q4288	Dermabind ch, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
0 (000		Clinical Review to avoid post-service review.			1010110000
Q4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
0.4000		Policy (CPCP).	= / / / 0 0 0 /		10/01/0000
Q4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4289	Revoshield + amniotic barrier, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4290	Membrane wrap-hydro, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4291	Lamellas xt, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
a		Not subject to pre-service review. Check EIU policy,	., ., _0		,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4292	Lamellas, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
a		Medical Policy Criteria. Submit for Recommended	0, 10,2021		
		Clinical Review to avoid post-service review.			
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
Q 1200		Not subject to pre-service review. Check EIU policy,		11112021	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
Q-1200		Not subject to pre-service review. Check EIU policy,	111/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4293	Acesso dl, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
Q 1200		Medical Policy Criteria. Submit for Recommended	0,10,2021		0/00/2021
		Clinical Review to avoid post-service review.			
Q4294	Amnio quad-core, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
Q7207		Not subject to pre-service review. Check EIU policy,		11112024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4294	Amnio quad-core, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
Q7207	Annio quad-core, per square contineter	Not subject to pre-service review. Check EIU policy,	111/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4294	Amnio quad-core, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
~		Medical Policy Criteria. Submit for Recommended	5, 10, 2024		5, 50, E0E I
		Clinical Review to avoid post-service review.			
Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		1, 1, 2024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
Q7200		Not subject to pre-service review. Check EIU policy,	111/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4295	Amnio tri-core amniotic, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4296	Rebound matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4297	Emerge matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service 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	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service 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.			12/31/2999
		Not subject to pre-service 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	3/15/2024		6/30/2024
		Medical Policy Criteria. Submit for Recommended			
		Clinical Review to avoid post-service review.			

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

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

Q4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/20	24 12/31/2999
		Not subject to pre-service review. Check EIU policy,	171120	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,	111/2024	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/20	24 12/31/2999
01012		Not subject to pre-service review. Check EIU policy,	111/20	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
a loiz		Not subject to pre-service review. Check EIU policy,	11 11 2021	12/01/2000
		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.	7/1/20	24 12/31/2999
		Not subject to pre-service 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.	7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/20	24 12/31/2999
		Not subject to pre-service 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.	7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/20	24 12/31/2999
		Not subject to pre-service 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.	7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/20	24 12/31/2999
		Not subject to pre-service 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.	7/1/2024	12/31/2999
		Not subject to pre-service 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.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
	····· 3·····, p···· - 1····· - ····	Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		.,	,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,	11112024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		1/1/2024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
01010	ounogran, per oquare continueter	Not subject to pre-service review. Check EIU policy,	111/2024		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
Q+020	r chogran, per square centimeter	Not subject to pre-service review. Check EIU policy,		1/1/2024	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
Q 1020	r onogran, por oquaro continiotor	Not subject to pre-service review. Check EIU policy,			12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
Q IOLI	richogran, por oquaro continictor	Not subject to pre-service review. Check EIU policy,		11 11 2021	12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
a		Not subject to pre-service review. Check EIU policy,	.,		12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
~	ourogran, por oquaro continiotor	Not subject to pre-service review. Check EIU policy,	1112024		,01,2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			

Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
04020		Not subject to pre-service review. Check EIU policy,			12/01/2000
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4324	Amniotx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
a		Not subject to pre-service 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.	7/1/2024		12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Not subject to pre-service review. Check EIU policy,			,
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.		7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,			
		which is one of our Clinical Payment and Coding			
		Policy (CPCP).			
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024		12/31/2999
		Not subject to pre-service 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.		7/1/2024	12/31/2999
		Not subject to pre-service 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.	7/1/2024		12/31/2999
		Not subject to pre-service 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.	7/1/2024	12/31/2999
	ongiay, por oquaro continucio	Not subject to pre-service review. Check EIU policy,	1111202	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,	.,	
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
0.4000		Policy (CPCP).	=///000	
Q4332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
Q4332	Axolotl dualgraft, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
Q4332	Axoloti dualgiali, per square centimeter	Not subject to pre-service review. Check EIU policy,	1/1/2024	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
Q+000	Aldeogran, per square centimeter	Not subject to pre-service review. Check EIU policy,	111/202-	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,	.,	
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q5106	Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000	MP Criteria: Procedure/service reviewed against	4/15/2020	12/31/2999
	units	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Q5128	Injection, ranibizumab-egrn (cimerli), biosimilar, 0.1 mg	MP Criteria: Procedure/service reviewed against	6/1/2023	12/31/2999
00120		Medical Policy Criteria. Submit for Recommended	0/ 1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/ 1/202 1	,,
		Clinical Review to avoid post-service review.		
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., ., === .	,,
l		Clinical Review to avoid post-service review.		
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0117	Tretinoin, topical, 5 grams	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	······································	Plan. Not subject to pre-service review.		
S0142	COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED		4/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
S0155	Sterile dilutant for epoprostenol, 50ml	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0157	Becaplermin gel 0. 01%, 0. 5 gm	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0189	Testosterone pellet, 75mg	MP Criteria: Procedure/service reviewed against	5/15/2010	3/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0197	PRENATAL VITAMINS, 30-DAY SUPPLY	Non Covered: Procedure/service not covered by the	4/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
S0207		Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	transport	Plan. Not subject to pre-service review.		
S0209	Wheelchair van, mileage, per mile	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
S0215	Non-emergency transportation; mileage, per mile	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0320	Telephone calls by a registered nurse to a disease management program	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S0596	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE	MP Criteria: Procedure/service reviewed against	4/1/2012	12/31/2999
	ERROR	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0800	Laser in situ keratomileusis (lasik)	Non Covered: Procedure/service not covered by the	11/1/2011	12/31/2999
		Plan. Not subject to pre-service review.		
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
S2080	Laser-assisted uvulopalatoplasty (laup)	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S2102	Islet cell tissue transplant from pancreas; allogeneic	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2103	Adrenal tissue transplant to brain	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
02100		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,	, .,	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral	MP Criteria: Procedure/service reviewed against	10/1/2008	12/31/2999
	components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2140	Cord blood harvesting for transplantation, allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2142	Cord blood-derived stem-cell transplantation, allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended	_, ., _0 . 0	,
		Clinical Review to avoid post-service review.		
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical),	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	allogeneic or autologous, harvesting, transplantation, and related	Medical Policy Criteria. Submit for Recommended		
	complications; including: pheresis and cell preparation/storage; marrow	Clinical Review to avoid post-service review.		
	ablative therapy; drugs, supplies, hospitalization with outpatient follow-up;			
	medical/surgical, diagnostic, emergency, and rehabilitative services; and			
	the number of days of pre-and post-transplant care in the global definition			
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2230	Implantation of magnetic component of semi-implantable hearing device	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	on ossicles in middle ear	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2400	Repair, congenital diaphragmatic hernia in the fetus using temporary	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	tracheal occlusion, procedure performed in utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
02101		Medical Policy Criteria. Submit for Recommended	10/ 11/20/20	12/01/2000
		Clinical Review to avoid post-service review.		
S2402	Repair, congenital cystic adenomatoid malformation in the fetus,	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	procedure performed in utero	Medical Policy Criteria. Submit for Recommended		/0 // 2000
		Clinical Review to avoid post-service review.		
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
02.00	performed in utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	······································	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
	utero	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2409	Repair, congenital malformation of fetus, procedure performed in utero,	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	not otherwise classified	Medical Policy Criteria. Submit for Recommended		,
		Clinical Review to avoid post-service review.		
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
	syndrome	Medical Policy Criteria. Submit for Recommended		,
	eynan enne	Clinical Review to avoid post-service review.		
S3600	Stat laboratory request (situations other than s3601)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S3601	Emergency stat laboratory charge for patient who is homebound or	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S3650	Saliva test, hormone level; during menopause	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	, , , , , ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3650	Saliva test, hormone level; during menopause	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3652	Saliva test, hormone level; to assess preterm labor risk	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3652	Saliva test, hormone level; to assess preterm labor risk	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3900	Surface electromyography (emg)	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3900	Surface electromyography (emg)	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

S4026	Procurement of donor sperm from sperm bank	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4027	Storage of previously frozen embryos	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4030	Sperm procurement and cryopreservation services; initial visit	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4031	Sperm procurement and cryopreservation services; subsequent visit	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5101	Day care services, adult; per half day	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5102	Day care services, adult; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5105	Day care services, center-based; services not included in program fee,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	per diem	Plan. Not subject to pre-service review.		
S5108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5109	Home care training to home care client, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5110	Home care training, family; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5111	Home care training, family; per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5116	Home care training, non-family; per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5120	Chore services; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5121	Chore services; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5135	Companion care, adult (e. G. ladl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

S5136	Companion care, adult (e. G. ladl/adl); per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
S5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00110		Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	., .,	
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	., .,	
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	-·····	Plan. Not subject to pre-service review.		
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5161	Emergency response system; service fee, per month (excludes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	installation and testing)	Plan. Not subject to pre-service review.		
S5162	Emergency response system; purchase only	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5165	Home modifications; per service	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5199	Personal care item, nos, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/299
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service 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.	11/1/2016	12/31/299
		Not subject to pre-service 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.	11/1/2016	12/31/2999
		Not subject to pre-service review. Check EIU policy,		12/01/2000
		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	7/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
S8415	Supplies for home delivery of infant	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S8460	Camisole, post-mastectomy	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000		Plan. Not subject to pre-service review.	44/4/0040	10/01/0000
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	11/1/2019	12/31/2999
00040		Clinical Review to avoid post-service review.	0/4/0000	10/01/0000
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy,	9/1/2020	12/31/2999
		which is one of our Clinical Payment and Coding Policy (CPCP).		
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
00040		Not subject to pre-service review. Check EIU policy,	0/ 1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S8948	Application of a modality (requiring constant provider attendance) to one	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	or more areas; low-level laser; each 15 minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	5	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	muscle rehabilitation device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9055	Procuren or other growth factor preparation to promote wound healing	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/1/2020	12/31/2999
		Not subject to pre-service 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.	12/15/2014	12/31/2999
		Not subject to pre-service 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.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU policy,	12/10/2014	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9117	Back school, per visit	MP Criteria: Procedure/service reviewed against	10/15/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9122	Home health aide or certified nurse assistant, providing care in the home;		1/1/1950	12/31/2999
	per hour	Plan. Not subject to pre-service review.		
S9125	Respite care, in the home, per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9436	Childbirth preparation/lamaze classes, non-physician provider, per	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	session	Plan. Not subject to pre-service review.		
S9437	Childbirth refresher classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9438	Cesarean birth classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9439	Vbac (vaginal birth after cesarean) classes, non-physician provider, per	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	session	Plan. Not subject to pre-service review.		
S9444	Parenting classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9447	Infant safety (including cpr) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9449	Weight management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S9451	Exercise classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00454		Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
S9454	Stress management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00400		Plan. Not subject to pre-service review.	4/4/0005	40/04/0000
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
S9558	Home injectable therapy; growth hormone, including administrative	Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
29000	services, professional pharmacy services, care coordination, and all	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
		-		
	necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Clinical Review to avoid post-service review.		
S9560	Home injectable therapy; hormonal therapy (e. G. ; leuprolide, goserelin),	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
03000	including administrative services, professional pharmacy services, care	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
	coordination, and all necessary supplies and equipment (drugs and	Clinical Review to avoid post-service review.		
	nursing visits coded separately), per diem	Cirrical Neview to avoid post-service review.		
S9900	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM	Plan. Not subject to pre-service review.		12/01/2000
S9960	Ambulance service, conventional air services, nonemergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	one way (fixed wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9961	Ambulance service, conventional air service, nonemergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	one way (rotary wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		

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V2718	Press-on lens, fresnell prism, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2730	Special base curve, glass or plastic, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2744	Tint, photochromatic, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2750	Anti-reflective coating, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2755	U-v lens, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2760	Scratch resistant coating, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2770	Occluder lens, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
V2799	Vision item or service, miscellaneous	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V5095	Semi-implantable middle ear hearing prosthesis	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
V5364	Dysphagia screening	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

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

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

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

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