

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

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

- Subject to a medical necessity review,
- Candidates for a Recommended Clinical Review,
- Not a benefit for our members,
- Considered experimental, investigational and unproven or
- Not on our prior authorization list (with some exceptions based on members' benefit plans)

Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025

**Utilization Management Process** 

This file is a searchable PDF.

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

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy criteria. Submit for Recommended Clinical Review to avoid post-service review.
	Highlighted procedure/service in this code group may require Prior Authorization per
	contract agreement.
Rotary Wing & Ground Ambulance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for
	Recommended Clinical Review to avoid post-service review. Managed by Alacura.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check
	EIU policy, which is one of our <u>Clinical Payment and Coding Policies</u> .
Unlisted or Undefined	Procedures/services not specifically defined or classified, may be subject to

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 cervical,		1/1/1950	12/31/2999
	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 including	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	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 additional 10	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.		
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	3 (3, 3, 7,	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
1.100.	cussual results in figure of mining material (egg, contagon), 1.1 to 0.0 co	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		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
11932	Subcutaneous injection of filling material (eg, collagen), 5.1 to 10.0 cc	Medical Policy Criteria. Submit for Recommended	17 17 1930	12/31/2999
		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
11954	Subcutaneous injection of filling material (eg. collagen), over 10.0 cc	Medical Policy Criteria. Submit for Recommended	1/1/1930	12/31/2999
11960	Insertion of tissue expander(s) for other than breast, including subsequent	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	3/1/2006	12/31/2999
11960			3/1/2006	12/31/2999
	expansion	Medical Policy Criteria. Submit for Recommended		
11070		Clinical Review to avoid post-service review.	0/4/0000	10/01/0000
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 and/or	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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 surface area	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	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 surface area	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof	Medical Policy Criteria. Submit for Recommended		
	(List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of			
	body area of infants and children	Clinical Review to avoid post-service review.		1

15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
1027 1	greater than or equal to 100 sq cm; each additional 100 sq cm wound surface	Medical Policy Criteria. Submit for Recommended	17 172020	12/01/2000
	area, or part thereof, or each additional 1% of body area of infants and children,	Clinical Review to avoid post-service review.		
	or part thereof (List separately in addition to code for primary procedure)	Offitioal Neview to avoid post service review.		
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up	Medical Policy Criteria. Submit for Recommended		
	to 100 sq cm; first 25 sq cm or less wound surface area	Clinical Review to avoid post-service review.		
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up	Medical Policy Criteria. Submit for Recommended		
	to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List	Clinical Review to avoid post-service review.		
	separately in addition to code for primary procedure)	·		
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area	Medical Policy Criteria. Submit for Recommended		
	greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of	Clinical Review to avoid post-service review.		
	body area of infants and children	·		
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area	Medical Policy Criteria. Submit for Recommended		
	greater than or equal to 100 sq cm; each additional 100 sq cm wound surface	Clinical Review to avoid post-service review.		
	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)			
15758	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, fat,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	dermis, fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	scalp, arms, and/or legs; 50 cc or less injectate	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List	Medical Policy Criteria. Submit for Recommended		
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
15775	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.		
15776	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.		
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	keratosis)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15781	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.		
15782	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.		
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 code	e for MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	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		1
		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		1
		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		1
		Clinical Review to avoid post-service review.	1	

15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	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.		
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	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.		
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	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.		
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	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.		
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	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.		
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	or hand	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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		
	'	Clinical Review to avoid post-service review.		
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	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 fascial	Medical Policy Criteria. Submit for Recommended		
	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 technique); less	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	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 technique); 10.0	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	to 50.0 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over		1/1/1950	12/31/2999
	50.0 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	ĺ

17340	Cryotherapy (CO2 slush, liquid N2) for acne	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	0. yourstapy (0.02 oldon, inquite 1.2) for doing	subject to pre-service review. Check EIU policy, which	, .,_0_0	1.2,0 1,2000
		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. Not	12/1/2020	12/31/2999
		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, each	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	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, saline,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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 mastectomy	MP Criteria: Procedure/service reviewed against	7/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		12/2//22
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 subsequent	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
	expansion(s)	Medical Policy Criteria. Submit for Recommended		1-7-77-10-1
	or pariotic (c)	Clinical Review to avoid post-service review.		
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy		1/1/1950	12/31/2999
	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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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 (eg,	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
	metastasis) including adjacent soft tissue when involved by tumor extension,	Medical Policy Criteria. Submit for Recommended		
	percutaneous, including imaging guidance when performed; radiofrequency	Clinical Review to avoid post-service review.		
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg,	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	metastasis) including adjacent soft tissue when involved by tumor extension,	Medical Policy Criteria. Submit for Recommended		
	percutaneous, including imaging guidance when performed; cryoablation	Clinical Review to avoid post-service review.		
20985	Computer-assisted surgical navigational procedure for musculoskeletal	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	procedures, image-less (List separately in addition to code for primary	subject to pre-service review. Check EIU policy, which		
	procedure)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
20985	Computer-assisted surgical navigational procedure for musculoskeletal	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	procedures, image-less (List separately in addition to code for primary	subject to pre-service review. Check EIU policy, which		
	procedure)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
21032	Excision of maxillary torus palatinus	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
	anesthesia service (ie, general or monitored anesthesia care)	Medical Policy Criteria. Submit for Recommended		
	ancomicona con mos (is, general of monitorea ancomicona cano)	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 excision or	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	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 (includes	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	obtaining autografts)	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
	obtaining datograno,	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	1, 1, 1000	12/01/2000
	mandibular staple sone plate,	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
21240	Tresonetraction of mandible of maxina, suspensored implant, partial	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
21240	Treconstruction of mandible of maxilla, subpenosteal implant, complete	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/3 1/2999
		Clinical Review to avoid post-service review.		
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder);	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
21240	partial	Plan. Not subject to pre-service review.	17 17 1950	12/3/1/2999
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder);	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
21210	complete	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	, y, ,	Medical Policy Criteria. Submit for Recommended		1-7-7-7-
		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
	manipalation of opinio roganing anisotropia, any rogion	Medical Policy Criteria. Submit for Recommended	, .,	12/01/2000
		Clinical Review to avoid post-service review.		
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	including fluoroscopic guidance; single level	subject to pre-service review. Check EIU policy, which	., .,	12/01/2000
	including hacroscopic galacines, emgle level	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	including fluoroscopic guidance; single level	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
	including hadrodopic galacitoc, dirigio lovoi	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
LLJLI	including fluoroscopic guidance; 1 or more additional levels (List separately in	subject to pre-service review. Check EIU policy, which	1/1/2023	12/3/1/2333
	addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
	addition to code for primary procedure)			
		(CPCP).		

22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
22321	including fluoroscopic guidance; 1 or more additional levels (List separately in	subject to pre-service review. Check EIU policy, which	1/1/2023	12/31/2999
	addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
	addition to code for primary procedure)	(CPCP).		
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	discectomy, with posterior instrumentation, with image guidance, includes bone	subject to pre-service review. Check EIU policy, which		
	graft when performed, L5-S1 interspace	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	discectomy, with posterior instrumentation, with image guidance, includes bone	subject to pre-service review. Check EIU policy, which		
	graft when performed, L5-S1 interspace	is one of our Clinical Payment and Coding Policy		
		(CPCP).		12/2//22
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	performed; up to 7 vertebral segments	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00000		(CPCP).	5/45/000A	10/04/0000
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	performed; up to 7 vertebral segments	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when	(CPCP).  MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
22030	performed; up to 7 vertebral segments	Medical Policy Criteria. Submit for Recommended	2/13/2024	5/14/2024
	performed, up to 7 vertebral segments	Clinical Review to avoid post-service review.		
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
22031	performed; 8 or more vertebral segments	subject to pre-service review. Check EIU policy, which	3/13/2024	12/3 1/2999
	performed, o or more vertebral segments	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. Not	5/15/2024	12/31/2999
	performed; 8 or more vertebral segments	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		
2222		Clinical Review to avoid post-service review.	=/4=/0004	10/01/0000
22838	Revision (eg, augmentation, division of tether), replacement, or removal of	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	thoracic vertebral body tethering, including thoracoscopy, when performed	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
22020	Revision (eg, augmentation, division of tether), replacement, or removal of	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	E/1E/2024	12/31/2999
22838	thoracic vertebral body tethering, including thoracoscopy, when performed	subject to pre-service review. Check EIU policy, which	5/15/2024	12/3 1/2999
	unoracic vertebrar body tetriering, including thoracoscopy, when performed	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22838	Revision (eg, augmentation, division of tether), replacement, or removal of	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
22000	thoracic vertebral body tethering, including thoracoscopy, when performed	Medical Policy Criteria. Submit for Recommended	2/10/2027	0,14,2024
	inorable vertebral body terriering, including inoracoscopy, when performed	Clinical Review to avoid post-service review.		
22867	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without fusion, including image guidance when performed, with open	subject to pre-service review. Check EIU policy, which	., ., 2020	.2,01,2000
	decompression, lumbar; single level	is one of our Clinical Payment and Coding Policy		
	assettiprocolon, lantibar, only of love			
	accompression, rumbar, single level	(CPCP).		

22867	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
22001	without fusion, including image guidance when performed, with open	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
	decompression, lumbar; single level	is one of our Clinical Payment and Coding Policy		
	decomplession, lumbal, single level	(CPCP).		
22868	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without fusion, including image guidance when performed, with open	subject to pre-service review. Check EIU policy, which		
	decompression, lumbar; second level (List separately in addition to code for	is one of our Clinical Payment and Coding Policy		
	primary procedure)	(CPCP).		
22868	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without fusion, including image guidance when performed, with open	subject to pre-service review. Check EIU policy, which		
	decompression, lumbar; second level (List separately in addition to code for	is one of our Clinical Payment and Coding Policy		
	primary procedure)	(CPCP).		
22869	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without open decompression or fusion, including image guidance when	subject to pre-service review. Check EIU policy, which		
	performed, lumbar; single level	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22869	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without open decompression or fusion, including image guidance when	subject to pre-service review. Check EIU policy, which		
	performed, lumbar; single level	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
22870	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without open decompression or fusion, including image guidance when	subject to pre-service review. Check EIU policy, which		
	performed, lumbar; second level (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
22870	Insertion of interlaminar/interspinous process stabilization/distraction device,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	without open decompression or fusion, including image guidance when	subject to pre-service review. Check EIU policy, which		
	performed, lumbar; second level (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
23929	procedure) Unlisted procedure, shoulder	(CPCP). MP Criteria: Procedure/service reviewed against	44/4/0047	40/04/0000
23929	Unlisted procedure, shoulder	_	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
24300	Manipulation, elbow, under anesthesia	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
24300	ivianipulation, elbow, under anestriesia	· ·	1/13/2013	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
20209	iwanipulation, what, under anestriesia	Medical Policy Criteria. Submit for Recommended	1/13/2013	12/31/2999
		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
20040	Maripalation, iniger joint, ander anestresia, easin joint	Medical Policy Criteria. Submit for Recommended	17 10/2010	12/01/2000
		Clinical Review to avoid post-service review.		
26341	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
	(eg, collagenase), single cord	Medical Policy Criteria. Submit for Recommended		1.2.5.,2555
	(vg, conagonaco), omgio cora	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
	general and an arranged and arranged ar	Medical Policy Criteria. Submit for Recommended	3. 10.2010	1.2.5.,2555
		Clinical Review to avoid post-service review.		
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]),	subject to pre-service review. Check EIU policy, which		.2.0.,200
	without placement of transfixation device	is one of our Clinical Payment and Coding Policy		
	marcat placement of transmittation device	(CPCP).		

27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]),	subject to pre-service review. Check EIU policy, which		
	without placement of transfixation device	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 device[s]),	Medical Policy Criteria. Submit for Recommended		
	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
		Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27860	Manipulation of ankle under general anesthesia (includes application of traction	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
	or other fixation apparatus)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
28890	Extracorporeal shock wave, high energy, performed by a physician or other	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	qualified health care professional, requiring anesthesia other than local, including			
	ultrasound guidance, involving the plantar fascia	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
28890	Extracorporeal shock wave, high energy, performed by a physician or other	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	qualified health care professional, requiring anesthesia other than local, including			
	ultrasound guidance, involving the plantar fascia	is one of our Clinical Payment and Coding Policy		
		(CPCP).	4/4/0000	10/01/0000
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		
20222		Clinical Review to avoid post-service review.	4/4/0005	10/04/0000
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	(includes harvesting of the autograft[s])	Medical Policy Criteria. Submit for Recommended		
00007	Authors and horse and had all and all all and the control at the c	Clinical Review to avoid post-service review.	0/45/0007	40/04/0000
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
29000	meniscal insertion), medial or lateral	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
	meniscal insertion), medial or lateral	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	Trumoscopy, mp, surgical, with remotoplasty (le, treatment of cam lesion)	Medical Policy Criteria. Submit for Recommended	1/ 1/2011	12/3 1/2333
		Clinical Review to avoid post-service review.		
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
23313	Paramoscopy, riip, surgical, with acetabuloplasty (ie, treathlefit of pilicel lesion)	Medical Policy Criteria. Submit for Recommended	1/ 1/2011	12/3 1/2333
		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
20010	Milliosoopy, filip, surgical, with labial tepali	Medical Policy Criteria. Submit for Recommended	1/ 1/2011	12/01/2000
		Clinical Review to avoid post-service review.		
J	1	Tommoar Neview to avoid post-service review.	I.	

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. Not	5/15/2021	12/31/2999
	implant(s)	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	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	implant(s)	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. Not	1/1/2023	12/31/2999
	radiofrequency) subcutaneous/submucosal remodeling	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. Not	1/1/2023	12/31/2999
	radiofrequency) subcutaneous/submucosal remodeling	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 ablation,	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	posterior nasal nerve	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 ablation,	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	posterior nasal nerve	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 ablation,	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.		
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	nerve	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, posterior nasal	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	nerve	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, posterior nasal		2/15/2024	5/14/2024
	nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31647		MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	with balloon occlusion, when performed, assessment of air leak, airway sizing,	Medical Policy Criteria. Submit for Recommended		
	and insertion of bronchial valve(s), initial lobe	Clinical Review to avoid post-service review.		
31648		MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	with removal of bronchial valve(s), initial lobe	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed;	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	with removal of bronchial valve(s), each additional lobe (List separately in	Medical Policy Criteria. Submit for Recommended		
	addition to code for primary procedure)	Clinical Review to avoid post-service review.		<b>i</b>

31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed;		11/1/2019	12/31/2999
	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])	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
31660		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		1/1/2013	12/31/2999
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33213	Insertion of pacemaker pulse generator only; with existing dual leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2006	12/31/2999
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	10/1/2019	12/31/2999
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	lead[s]), including vessel catheterization, all imaging guidance, and pulse	Medical Policy Criteria. Submit for Recommended		
	generator initial analysis with diagnostic mode activation, when performed	Clinical Review to avoid post-service review.		
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in		5/15/2024	12/31/2999
	addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
2227		(CPCP).	2/15/2024	F/4.4/2024
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in	Medical Policy Criteria. Submit for Recommended	2/15/2024	5/14/2024
	addition to code for primary procedure)	Clinical Review to avoid post-service review.		
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		5/15/2024	12/31/2999
33270	guidance, and interrogation and programming, when performed; system,	subject to pre-service review. Check EIU policy, which	10/10/2024	12/3 1/2999
	including pulse generator and lead(s)	is one of our Clinical Payment and Coding Policy		
	including pulse generator and lead(3)	(CPCP).		
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		5/15/2024	12/31/2999
	guidance, and interrogation and programming, when performed; system,	subject to pre-service review. Check EIU policy, which		
	including pulse generator and lead(s)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		2/15/2024	5/14/2024
	guidance, and interrogation and programming, when performed; system,	Medical Policy Criteria. Submit for Recommended		
	including pulse generator and lead(s)	Clinical Review to avoid post-service review.		
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		5/15/2024	12/31/2999
	guidance, and interrogation and programming, when performed; transvenous	subject to pre-service review. Check EIU policy, which		
	stimulation or sensing lead(s) only	is one of our Clinical Payment and Coding Policy		
00070		(CPCP).	F/4F/0004	40/04/0000
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous	subject to pre-service review. Check EIU policy, which	5/15/2024	12/31/2999
	stimulation or sensing lead(s) only	is one of our Clinical Payment and Coding Policy		
	sumulation of sensing lead(s) only	(CPCP).		
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		2/15/2024	5/14/2024
00270	guidance, and interrogation and programming, when performed; transvenous	Medical Policy Criteria. Submit for Recommended	2/10/2024	0/14/2024
	stimulation or sensing lead(s) only	Clinical Review to avoid post-service review.		
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
	only	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging	•	5/15/2024	12/31/2999
	guidance, and interrogation and programming, when performed; pulse generator	subject to pre-service review. Check EIU policy, which		
	only	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging		2/15/2024	5/14/2024
		Medical Policy Criteria. Submit for Recommended		
	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. Not	5/15/2024	12/31/2999
33201	Trepositioning of priferile fierve stitutator transverious lead(s)	subject to pre-service review. Check EIU policy, which	3/13/2024	12/31/2999
		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. Not	5/15/2024	12/31/2999
		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. Not	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and programming, when	subject to pre-service review. Check EIU policy, which		
	performed; pulse generator	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. Not	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and programming, when	subject to pre-service review. Check EIU policy, which		
	performed; pulse generator	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, when	Medical Policy Criteria. Submit for Recommended		
	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. Not	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and programming, when	subject to pre-service review. Check EIU policy, which		
	performed; transvenous stimulation or sensing lead(s)	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. Not	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and programming, when	subject to pre-service review. Check EIU policy, which		
	performed; transvenous stimulation or sensing lead(s)	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, when	Medical Policy Criteria. Submit for Recommended		
	performed; transvenous stimulation or sensing lead(s)	Clinical Review to avoid post-service review.		
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	term hemodynamic monitoring, including deployment and calibration of the	Medical Policy Criteria. Submit for Recommended		
	sensor, right heart catheterization, selective pulmonary catheterization,	Clinical Review to avoid post-service review.		
	radiological supervision and interpretation, and pulmonary artery angiography,			
	when performed			
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	percutaneous femoral artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		<u> </u>
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
1	femoral artery approach	Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		1
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
1	axillary artery approach	Medical Policy Criteria. Submit for Recommended	1	1
	axillary aftery approach	Inicalcal Folicy Official Submit for Recommended		

33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	iliac artery approach	Medical Policy Criteria. Submit for Recommended	, .,	12,01,200
	indo ditory approach	Clinical Review to avoid post-service review.		
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	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 valve;	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	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 valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	cardiopulmonary bypass support with percutaneous peripheral arterial and	Medical Policy Criteria. Submit for Recommended		
	venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	cardiopulmonary bypass support with open peripheral arterial and venous	Medical Policy Criteria. Submit for Recommended	., .,	
	cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to	Clinical Review to avoid post-service review.		
	code for primary procedure)			
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	cardiopulmonary bypass support with central arterial and venous cannulation (eg,			
	aorta, right atrium, pulmonary artery) (List separately in addition to code for	Clinical Review to avoid post-service review.		
	primary procedure)	·		
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
	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 transseptal	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
	puncture when performed; additional prosthesis(es) during same session (List	Medical Policy Criteria. Submit for Recommended		
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	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 recipient	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	cardiectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33928	Removal and replacement of total replacement heart system (artificial heart)	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
22222		Clinical Review to avoid post-service review.	11/1/0017	10/04/0000
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
36465	Injection of non-compounded foam sclerosant with ultrasound compression	Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
30403	maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2016	12/31/2999
	and monitoring; single incompetent extremity truncal vein (eg, great saphenous	Clinical Review to avoid post-service review.		
	vein, accessory saphenous vein)	Cililical Review to avoid post-service review.		
36466	Injection of non-compounded foam sclerosant with ultrasound compression	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
<del>55400</del>	maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/3/1/2333
	and monitoring; multiple incompetent truncal veins (eg, great saphenous vein,	Clinical Review to avoid post-service review.		
	and mornioring, multiple incompetent trutical veins (eg, great sapitenous vein, accessory saphenous vein), same leg	Ominical review to avoid post-service review.		
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 1,20 12	12/01/2000
		Clinical Review to avoid post-service review.		
	I	Omnoul Noview to avoid post-service review.		

36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	8/1/2006	12/31/2999
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
00000	both the peripheral artery and peripheral vein, including fistula maturation	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
	procedures (eg, transluminal balloon angioplasty, coil embolization) when	is one of our Clinical Payment and Coding Policy		
	performed, including all vascular access, imaging guidance and radiologic	(CPCP).		
	supervision and interpretation	(61 61 ).		
36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	both the peripheral artery and peripheral vein, including fistula maturation	subject to pre-service review. Check EIU policy, which		
	procedures (eg, transluminal balloon angioplasty, coil embolization) when	is one of our Clinical Payment and Coding Policy		
	performed, including all vascular access, imaging guidance and radiologic	(CPCP).		
	supervision and interpretation			
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	sites of the peripheral artery and peripheral vein, including fistula maturation	subject to pre-service review. Check EIU policy, which		
	procedures (eg, transluminal balloon angioplasty, coil embolization) when	is one of our Clinical Payment and Coding Policy		
	performed, including all vascular access, imaging guidance and radiologic	(CPCP).		
	supervision and interpretation			
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	sites of the peripheral artery and peripheral vein, including fistula maturation	subject to pre-service review. Check EIU policy, which		
	procedures (eg, transluminal balloon angioplasty, coil embolization) when	is one of our Clinical Payment and Coding Policy		
	performed, including all vascular access, imaging guidance and radiologic	(CPCP).		
07045	supervision and interpretation	NDO'' : D	44/45/0000	10/04/0000
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or		11/15/2006	12/31/2999
	percutaneous, including angioplasty, when performed, and radiological	Medical Policy Criteria. Submit for Recommended		
37216	supervision and interpretation; with distal embolic protection  Transcatheter placement of intravascular stent(s), cervical carotid artery, open or	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
3/210	percutaneous, including angioplasty, when performed, and radiological	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
	supervision and interpretation; without distal embolic protection	Clinical Review to avoid post-service review.		
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
01211	artery or innominate artery by retrograde treatment, open ipsilateral cervical	Medical Policy Criteria. Submit for Recommended	10/10/2014	12/01/2000
	carotid artery exposure, including angioplasty, when performed, and radiological	Clinical Review to avoid post-service review.		
	supervision and interpretation	Offition review to avoid post service review.		
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	artery or innominate artery, open or percutaneous antegrade approach, including	Medical Policy Criteria. Submit for Recommended		
	angioplasty, when performed, and radiological supervision and interpretation	Clinical Review to avoid post-service review.		
07044		IMP O II I I	4/4/004	40/04/0000
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	interpretation, intraprocedural roadmapping, and imaging guidance necessary to	Medical Policy Criteria. Submit for Recommended		
	complete the intervention; venous, other than hemorrhage (eg, congenital or	Clinical Review to avoid post-service review.		
	acquired venous malformations, venous and capillary hemangiomas, varices,			
37242	varicoceles)  Vascular embolization or occlusion, inclusive of all radiological supervision and	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
31 242	interpretation, intraprocedural roadmapping, and imaging guidance necessary to	Medical Policy Criteria. Submit for Recommended	1/ 1/2014	12/3 1/2999
	complete the intervention; arterial, other than hemorrhage or tumor (eg,	Clinical Review to avoid post-service review.		
	complete the intervention, arterial, other than hemorrhage of turnor (eg, congenital or acquired arterial malformations, arteriovenous malformations,	Cililical Neview to avoid post-service review.		
	arteriovenous fistulas, aneurysms, pseudoaneurysms)			
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
0,270		Medical Policy Criteria. Submit for Recommended	17 172014	12/01/2000
	complete the intervention; for tumors, organ ischemia, or infarction	Clinical Review to avoid post-service review.		
	reomplete the intervention, for turnors, organ ischemia, or initaletion	Tommoar Neview to avoid post-service review.	l	

37244	Vascular embolization or occlusion, inclusive of all radiological supervision and	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	interpretation, intraprocedural roadmapping, and imaging guidance necessary to	Medical Policy Criteria. Submit for Recommended	17 172011	12/01/2000
	complete the intervention; for arterial or venous hemorrhage or lymphatic	Clinical Review to avoid post-service review.		
	extravasation	Cimiladi Mavian ta dvala paat aarvica ravien.		
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)		8/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	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
1	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 veins	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	with radical excision of ulcer and skin graft and/or interruption of communicating	Medical Policy Criteria. Submit for Recommended		
	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 graft,	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	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 guidance,	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	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	MP Criteria: Procedure/service reviewed against	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
		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 cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	acquisition	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	collection; allogeneic	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per	MP Criteria: Procedure/service reviewed against	1/1/1950	1/31/2024
I	collection; autologous	Medical Policy Criteria. Submit for Recommended		
<u>                                       </u>		Clinical Review to avoid post-service review.		

38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
	storage	1		
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30200		•	1/1/1950	12/31/2999
	frozen harvest, without washing, per donor	Medical Policy Criteria. Submit for Recommended		
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
36209	frozen harvest, with washing, per donor	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
	rozen harvest, with washing, per donor	•		
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30210	within harvest, T-cell depletion	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
	within narvest, 1-cell depletion	Clinical Review to avoid post-service review.		
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30211	Transplant preparation of hematopoletic progenitor cens, tumor cen depletion	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
		Clinical Review to avoid post-service review.		
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30212	Transplant preparation of hematopoletic progenitor cens, red blood centremoval	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
		Clinical Review to avoid post-service review.		
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30213	Transplant preparation of hematopoletic progenitor cens, platelet depletion	Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
		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
30214	depletion	Medical Policy Criteria. Submit for Recommended	17 17 1330	12/01/2000
	depiction	Clinical Review to avoid post-service review.		
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30213	plasma, mononuclear, or buffy coat layer	Medical Policy Criteria. Submit for Recommended	17 17 1330	12/01/2000
	plasma, mononuclear, or buny coat layer	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
00200	Bono manow harvesting for transplantation, allogonore	Medical Policy Criteria. Submit for Recommended	17 17 1000	170172024
		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
00202	bono manon narvosang for transplantation, autologous	Medical Policy Criteria. Submit for Recommended	17 172012	12/01/2000
		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
00210	Trematepoiette progeniter een (i'ii e), anegenete transplantation per dener	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		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
002	rismatopologo progomer com (rin o), autologodo namopiamadon	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
	J,	Medical Policy Criteria. Submit for Recommended	1	1-1-1-1-1-1
		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	., ., 20 . 0	13/0 //2000
		Clinical Review to avoid post-service review.	1	
38308	Lymphangiotomy or other operations on lymphatic channels	MP Criteria: Procedure/service reviewed against	12/1/2014	12/31/2999
	= jp.ia.ig.c.oniy or other operations on tymphatic originals	Medical Policy Criteria. Submit for Recommended	1.2, 1,2011	12/01/2000
		Clinical Review to avoid post-service review.	1	
		Chillical Neview to avoid post-service leview.		

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, per	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	3/31/2024
	session	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, per		12/1/2020	3/31/2024
	session	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, per	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	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, uvulopharyngoplasty)	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.		
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.		12/21/22/2
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
10000		(CPCP).	0/4/0000	10/04/0000
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
10010	Combana and the desire of the form and with a combana and the	(CPCP).	7/45/0040	40/04/0000
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		
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
43230		_	1/1/1950	12/31/2999
	injection(s), any substance	Medical Policy Criteria. Submit for Recommended		
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
43232	Esophagogastroduodenoscopy, nexibie, transorar, with optical endomicroscopy	subject to pre-service review. Check EIU policy, which	9/1/2020	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		I(OFOF).		

43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
40202	Esophagogastroddodenoscopy, nexible, transoral, with optical endomicroscopy	subject to pre-service review. Check EIU policy, which	3/1/2020	12/31/2999
		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, for	Medical Policy Criteria. Submit for Recommended		
	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), including	Medical Policy Criteria. Submit for Recommended		
	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 intragastric	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	bariatric balloon	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 intragastric	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	bariatric balloon	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 intragastric	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	bariatric balloon(s)	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 intragastric	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	bariatric balloon(s)	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 and	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and	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.		
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	gastric restrictive device (eg, gastric band and subcutaneous port components)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	restrictive device component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric		1/1/2006	12/31/2999
	restrictive device component only	Medical Policy Criteria. Submit for Recommended		
ı		Clinical Review to avoid post-service review.		

43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	adjustable gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
	adjustable gastile restrictive device component only	Clinical Review to avoid post-service review.		
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric		1/1/2006	12/31/2999
	restrictive device and subcutaneous port components	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
	Tostrictive device and subcutaneous port components	Clinical Review to avoid post-service review.		
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie,	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	sleeve gastrectomy)	Medical Policy Criteria. Submit for Recommended	,,,,_,,,	
	guaranta my	Clinical Review to avoid post-service review.		
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	banded gastroplasty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other	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.		
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving		9/15/2009	12/31/2999
	duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit	Medical Policy Criteria. Submit for Recommended		
	absorption (biliopancreatic diversion with duodenal switch)	Clinical Review to avoid post-service review.		
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	limb (150 cm or less) Roux-en-Y gastroenterostomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	intestine reconstruction to limit absorption	Medical Policy Criteria. Submit for Recommended		
	·	Clinical Review to avoid post-service review.		
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	adjustable gastric restrictive device (separate procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43886	Gastric restrictive procedure, open; revision of subcutaneous port component	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43887	Gastric restrictive procedure, open; removal of subcutaneous port component	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	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 donor	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	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 submucosa	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	[SIS])	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 submucosa	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	[SIS])	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	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.		

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		
	manaperative and account galaxies and members, personned	Clinical Review to avoid post-service review.		
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	MP Criteria: Procedure/service reviewed against	5/15/2016	12/31/2999
	Terrai anonanopiamanon, impiamanon or grant, intiroat roopioni nopinosioni,	Medical Policy Criteria. Submit for Recommended	0, 10,2010	1.2,0 1,2000
		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
00011	Laparosoppy, ourgious, ablation of rottal oyoto	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00012	ultrasound guidance and monitoring, when performed	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	untassana garaanse ana memering, when performed	Clinical Review to avoid post-service review.		
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
00002	/ Mation, 1 of More remarkation (9), percutarious, unitation, radionoquency	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
		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
00000	Tibiditori, Forial tarrior(o), armatoral, porodiamosas, oryothorapy	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
51715	Endoscopic injection of implant material into the submucosal tissues of the	MP Criteria: Procedure/service reviewed against	5/1/2007	12/31/2999
517 15	urethra and/or bladder neck	Medical Policy Criteria. Submit for Recommended	3/1/2007	12/3 1/2333
	uletilla aliu/oi biaduel fleok	Clinical Review to avoid post-service review.		
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
02204	drug delivery by drug-coated balloon catheter for urethral stricture or stenosis,	subject to pre-service review. Check EIU policy, which	0/10/2024	12/01/2000
	male, including fluoroscopy, when performed	is one of our Clinical Payment and Coding Policy		
	male, including hubroscopy, when performed	(CPCP).		
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
32204	drug delivery by drug-coated balloon catheter for urethral stricture or stenosis,	subject to pre-service review. Check EIU policy, which	3/13/2024	12/3 1/2333
	male, including fluoroscopy, when performed	is one of our Clinical Payment and Coding Policy		
	male, including hadroscopy, when performed	(CPCP).		
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
32204	drug delivery by drug-coated balloon catheter for urethral stricture or stenosis,	Medical Policy Criteria. Submit for Recommended	2/13/2024	3/14/2024
	male, including fluoroscopy, when performed	Clinical Review to avoid post-service review.		
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
02021	of implant material	Medical Policy Criteria. Submit for Recommended	0, 1,2011	12/01/2009
	of implant material	Clinical Review to avoid post-service review.		
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant;	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
J274 I	single implant	Medical Policy Criteria. Submit for Recommended	12/1/2013	12/3 1/2999
	Single implant	Clinical Review to avoid post-service review.		
	L	Tolinical Review to avoid post-service review.		1

52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	9/30/2024
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	9/30/2024
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	9/30/2024
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	9/30/2024

53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	moonion of a temporary procedure arounal etchi, mountaining arounal mountain	subject to pre-service review. Check EIU policy, which		12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
		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 measurement	MP Criteria: Procedure/service reviewed against	10/15/2020	5/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	proximal urethra for stress urinary incontinence	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	proximal urethra for stress urinary incontinence	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
54125	Amputation of penis; complete	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.		
54200	Injection procedure for Peyronie disease;	MP Criteria: Procedure/service reviewed against	12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	MP Criteria: Procedure/service reviewed against	12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54240	Penile plethysmography	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.		
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 placement of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	pump, cylinders, and reservoir	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54406	Removal of all components of a multi-component, inflatable penile prosthesis	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	without replacement of prosthesis	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54408	Repair of component(s) of a multi-component, inflatable penile 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.		
54410	Removal and replacement of all component(s) of a multi-component, inflatable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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 inflatable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	penile prosthesis through an infected field at the same operative session,	Medical Policy Criteria. Submit for Recommended		
	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 operative	Medical Policy Criteria. Submit for Recommended		
	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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
	sampling, including imaging guidance	Medical Policy Criteria. Submit for Recommended		
		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
	monitoring)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	ultrasound (HIFU), including ultrasound guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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
		Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		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
	approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

57335	Vaginoplasty 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.		
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		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
		Plan. Not subject to pre-service review.		
58322	Artificial insemination; intra-uterine	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
58323	Sperm washing for artificial insemination	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	guidance and monitoring, radiofrequency	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
58750	Tubotubal anastomosis	Non Covered: Procedure/service not covered by the	1/15/2008	12/31/2999
		Plan. Not subject to pre-service review.		
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), percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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), percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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 infusion for	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	thrombolysis, intracranial, any method, including diagnostic angiography,	Medical Policy Criteria. Submit for Recommended		
	fluoroscopic guidance, catheter placement, and intraprocedural pharmacological	Clinical Review to avoid post-service review.		
	thrombolytic injection(s)			
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	hole(s), with magnetic resonance imaging guidance, when performed; single	Medical Policy Criteria. Submit for Recommended		
	trajectory for 1 simple lesion	Clinical Review to avoid post-service review.		
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	hole(s), with magnetic resonance imaging guidance, when performed; multiple	Medical Policy Criteria. Submit for Recommended		
	trajectories for multiple or complex lesion(s)	Clinical Review to avoid post-service review.		

61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	in addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which		1.2.3.3.2.3
	in addition to code for printary procedure)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	in addition to code for primary procedure)	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 separately	MP Criteria: Procedure/service reviewed against	5/15/2024	6/30/2024
	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 receiver,	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	including craniectomy or craniotomy, when performed, with direct or inductive	Medical Policy Criteria. Submit for Recommended		
	coupling, with connection to depth and/or cortical strip electrode array(s)	Clinical Review to avoid post-service review.		
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 electrode	Medical Policy Criteria. Submit for Recommended		
	array(s)	Clinical Review to avoid post-service review.		
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	with cranioplasty, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
62263		EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	saline, enzyme) or mechanical means (eg, catheter) including radiologic	subject to pre-service review. Check EIU policy, which		
	localization (includes contrast when administered), multiple adhesiolysis	is one of our Clinical Payment and Coding Policy		
	sessions; 2 or more days	(CPCP).		
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	saline, enzyme) or mechanical means (eg, catheter) including radiologic	subject to pre-service review. Check EIU policy, which		
	localization (includes contrast when administered), multiple adhesiolysis	is one of our Clinical Payment and Coding Policy		
	sessions; 2 or more days	(CPCP).		
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	saline, enzyme) or mechanical means (eg, catheter) including radiologic	subject to pre-service review. Check EIU policy, which		
	localization (includes contrast when administered), multiple adhesiolysis	is one of our Clinical Payment and Coding Policy		
	sessions; 1 day	(CPCP).		
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	saline, enzyme) or mechanical means (eg, catheter) including radiologic	subject to pre-service review. Check EIU policy, which		
	localization (includes contrast when administered), multiple adhesiolysis	is one of our Clinical Payment and Coding Policy		
	sessions; 1 day	(CPCP).		
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	disc, any method utilizing needle based technique to remove disc material under	subject to pre-service review. Check EIU policy, which		
	fluoroscopic imaging or other form of indirect visualization, with discography	is one of our Clinical Payment and Coding Policy		
	and/or epidural injection(s) at the treated level(s), when performed, single or	(CPCP).		
	multiple levels, lumbar	,		
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	disc, any method utilizing needle based technique to remove disc material under	subject to pre-service review. Check EIU policy, which		
	fluoroscopic imaging or other form of indirect visualization, with discography	is one of our Clinical Payment and Coding Policy		
	and/or epidural injection(s) at the treated level(s), when performed, single or	(CPCP).		
	multiple levels, lumbar			
64555	Percutaneous 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		
	ľ.	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		
	a sautioni, motaco programming	Clinical Review to avoid post-service review.		
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	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 (excludes		1/1/2022	12/31/2999
	sacral nerve)	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator,	MP Criteria: Procedure/service reviewed against	5/1/2022	3/14/2024
	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 pulse	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	generator or receiver, requiring pocket creation and connection between	Medical Policy Criteria. Submit for Recommended		
	electrode array and pulse generator or receiver	Clinical Review to avoid post-service review.		
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	integrated neurostimulator, including imaging guidance, when performed; initial	Medical Policy Criteria. Submit for Recommended		
	electrode array	Clinical Review to avoid post-service review.		
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	integrated neurostimulator, including imaging guidance, when performed; each	Medical Policy Criteria. Submit for Recommended		
	additional electrode array (List separately in addition to code for primary	Clinical Review to avoid post-service review.		
	procedure)			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	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 imaging	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	guidance; first 2 vertebral bodies, lumbar or sacral	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 imaging	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	guidance; first 2 vertebral bodies, lumbar or sacral	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 imaging	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	guidance; each additional vertebral body, lumbar or sacral (List separately in	subject to pre-service review. Check EIU policy, which		
	addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
	guidance; each additional vertebral body, lumbar or sacral (List separately in	subject to pre-service review. Check EIU policy, which		
	addition to code for primary procedure)	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	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	1101410-110110	Medical Policy Criteria. Submit for Recommended	0,2 1,20 12	12/01/2000
		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
00112	Control Total Indicator for Control of Carginally Induced actignation	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
		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
00110	Combai modgo roccolom for confecunty induced deligitation	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
		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
00700	Implantation of intractional conteat mig segments	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
		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
00174	retention of device or stent	Medical Policy Criteria. Submit for Recommended	0/10/2012	12/3 1/2333
	reterition of device of Sterit	Clinical Review to avoid post-service review.		
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
00173	of device or stent	Medical Policy Criteria. Submit for Recommended	0/13/2012	12/3 1/2999
	of device of stellt	Clinical Review to avoid post-service review.		
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach;	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
00179	without graft	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/31/2999
	without grant	Clinical Review to avoid post-service review.		
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
00100	graft	Medical Policy Criteria. Submit for Recommended	3/1/2021	12/3 1/2999
	gran	Clinical Review to avoid post-service review.		
66183	Insertion of anterior segment aqueous drainage device, without extraocular	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
00100	reservoir, external approach	Medical Policy Criteria. Submit for Recommended	17 172014	12/01/2000
	reservoir, externar approach	Clinical Review to avoid post-service review.		
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-	MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
00000	stage procedure), manual or mechanical technique (eg, irrigation and aspiration	Medical Policy Criteria. Submit for Recommended	0/10/2022	12/01/2000
	or phacoemulsification), complex, requiring devices or techniques not generally	Clinical Review to avoid post-service review.		
	used in routine cataract surgery (eg, iris expansion device, suture support for	Cililical Neview to avoid post-service review.		
	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 prosthesis (1	MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
00001	stage procedure), manual or mechanical technique (eg, irrigation and aspiration	Medical Policy Criteria. Submit for Recommended	0/10/2022	12/01/2000
	or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork,	Clinical Review to avoid post-service review.		
	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
0.020	This artificial injudical of a pharmacologic agent (Separate procedure)	Medical Policy Criteria. Submit for Recommended	0/10/2020	170172024
		Clinical Review to avoid post-service review.		
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
0,010	Supractional space injection of pharmacologic agent (separate procedure)	Medical Policy Criteria. Submit for Recommended	2/10/2024	12/01/2009
		Clinical Review to avoid post-service review.		
	I	Cimical Neview to avoid post-service review.	1	1

	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
(eg, banked fascia)	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
		1/1/2005	12/31/2999
(includes obtaining fascia)	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Repair of blepharoptosis; (tarso) levator resection or advancement, internal		1/1/2005	12/31/2999
approach	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Repair of blepharoptosis; (tarso) levator resection or advancement, external	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
approach	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Repair of blepharoptosis; superior rectus technique with fascial sling (includes	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
obtaining fascia)	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
Fasanella-Servat type)	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Ear piercing	Non Covered: Procedure/service not covered by the	1/1/2020	12/31/2999
	Plan. Not subject to pre-service review.		
Otoplasty, protruding ear, with or without size reduction		1/1/1950	12/31/2999
	Clinical Review to avoid post-service review.		
Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	Medical Policy Criteria. Submit for Recommended		
	<u> </u>		
Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon		1/15/2021	12/31/2999
· · · · · · · · · · · · · · · · · · ·	l		
	1		
Implantation, osseointegrated implant, skull; with magnetic transcutaneous		12/15/2022	12/31/2999
· · · · · · · · · · · · · · · · · · ·	l		
· · · · · · · · · · · · · · · · · · ·			
	MP Criteria: Procedure/service reviewed against	12/15/2022	12/31/2999
· · · · · · · · · · · · · · · · · · ·	omnour remain to arona poor con noc remain		
	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
			1-1-1-1-1-1
· · · · · · · · · · · · · · · · · · ·			
	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
			12,01,2000
· · ·	Cillingal Review to avoid post-service review.		
	(includes obtaining fascia)  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)  Ear piercing  Otoplasty, protruding ear, with or without size reduction  Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral  Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral  Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex  Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex  Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex  Implantation, osseointegrated implant, skull; with magnetic transcutaneous	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. Fasanella-Servat type)  Ear piercing  Ansopharyngoscopy, surgical, with or without size reduction  Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral  Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral  Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and irovolving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex.  Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and resulting in removal of gester than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex.  Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and resulting in removal of gester than or equal to 100 sq mm surface area of bone deep to the outer overallal cortex.  Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and resulting in removal of gester than or equal to 100 sq m	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; (tarso) levator resection or advancement, external approach  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. MP Criteria: Procedure/service reviewed under the content of the plan. Not subject to post-service review.  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. MP Criteria: Procedure/service reviewed under the plan. Not subject to post-service reviewed.  Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg. MP Criteria: Procedure/service reviewed under the plan. Not subject to post-service reviewed.  Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed deginst Medical Policy Criteria. Submit for Recommended Clinical Revie

69730	Replacement (including removal of existing device), osseointegrated implant,	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
00.00	skull; with magnetic transcutaneous attachment to external speech processor,	Medical Policy Criteria. Submit for Recommended	., .,	1.2,0 1,200
	outside the mastoid and involving a bony defect greater than or equal to 100 sg	Clinical Review to avoid post-service review.		
	mm surface area of bone deep to the outer cranial cortex	μ		
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 (List	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	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. Not	12/15/2014	12/31/2999
		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. Not	12/15/2014	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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 lipoproteins	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	including lipoprotein subclasses when performed (eg, electrophoresis,	subject to pre-service review. Check EIU policy, which		
	ultracentrifugation)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	including lipoprotein subclasses when performed (eg, electrophoresis,	subject to pre-service review. Check EIU policy, which		
	ultracentrifugation)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	magnetic resonance spectroscopy), includes lipoprotein particle subclass(es),	subject to pre-service review. Check EIU policy, which		
	when performed	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
00701	magnetic resonance spectroscopy), includes lipoprotein particle subclass(es),	subject to pre-service review. Check EIU policy, which	0/ 1/2020	12/01/2000
	when performed	is one of our Clinical Payment and Coding Policy		
	The state of the s	(CPCP).		
83722	Lipoprotein, direct measurement; small dense LDL cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999
		(CPCP).		
83937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
2222		(CPCP).	0/4/0000	10/04/0000
83937	Osteocalcin (bone g1a protein)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
83987	pH; exhaled breath condensate	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/21/2000
03901	pri, exhaled breath condensate	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
83987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
00001	pri, oxidated broadir condensate	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
		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. Not	9/1/2020	12/31/2999
	placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-	subject to pre-service review. Check EIU policy, which		
	fetoprotein), qualitative, each specimen	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. Not	9/1/2020	12/31/2999
	placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-	subject to pre-service review. Check EIU policy, which		
	fetoprotein), qualitative, each specimen	is one of our Clinical Payment and Coding Policy		
04404	The section of the life / a Visabellian through a section of sections of sections.	(CPCP).	0/4/0000	40/04/0000
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
07701	Thiomboxane metabolite(s), including thromboxane it performed, diffie	subject to pre-service review. Check EIU policy, which	3/ 1/2020	12/3 1/2393
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	,	0.,200
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

86001	Allergen enecific IaC quantitative or comiguantitative, each allergen	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
00001	Allergen specific IgG quantitative or semiquantitative, each allergen		12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00000		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/4/0000	40/04/0000
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative,		6/1/2023	12/31/2999
	single-step method (eg, reagent strip); severe acute respiratory syndrome	subject to pre-service review. Check EIU policy, which		
	coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	is one of our Clinical Payment and Coding Policy		
00000		(CPCP).	0/4/0000	40/04/0000
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative,	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	single-step method (eg, reagent strip); severe acute respiratory syndrome	subject to pre-service review. Check EIU policy, which		
	coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	is one of our Clinical Payment and Coding Policy		
00040	1 1 ( 1 : ( : 1	(CPCP).	40/4/0000	10/04/0000
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999  12/31/2999
		(CPCP).		
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
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 (SARS-	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	CoV-2) (coronavirus disease [COVID-19]); screen	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		121211222
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	CoV-2) (coronavirus disease [COVID-19]); screen	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00400	N	(CPCP).	0/4/0000	10/04/0000
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	CoV-2) (coronavirus disease [COVID-19]); titer	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00.100		(CPCP).	0///0000	10/01/0000
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	CoV-2) (coronavirus disease [COVID-19]); titer	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
22442	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(CPCP).	0/4/0000	10/04/0000
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	disease [COVID-19]) antibody, quantitative	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) (coronavirus	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	disease [COVID-19]) antibody, quantitative	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-2)	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
00.00	(coronavirus disease [COVID-19])	subject to pre-service review. Check EIU policy, which	07.172020	12/01/2000
	(VOTOTICATION CIOCASO [OCT VID 10])	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	(coronavirus disease [COVID-19])	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 system	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		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
	pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus,	Medical Policy Criteria. Submit for Recommended		
	Giardia), includes multiplex reverse transcription, when performed, and multiplex	Clinical Review to avoid post-service review.		
	amplified probe technique, multiple types or subtypes, 3-5 targets			
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal	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 multiplex	Clinical Review to avoid post-service review.		
	amplified probe technique, multiple types or subtypes, 6-11 targets			
87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal	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 multiplex	Clinical Review to avoid post-service review.		
00000	amplified probe technique, multiple types or subtypes, 12-25 targets		4/4/4050	10/04/0000
88000	Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00005		Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
88005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
88007	Negranay (autonay) grace examination only with brain and oningle card	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00007	Necropsy (autopsy), gross examination only; with brain and spinal cord		1/1/1950	12/3 1/2999
88012	Necropsy (autopsy), gross examination only; infant with brain	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00012	inecropsy (autopsy), gross examination only, infant with brain		1/1/1950	12/3 1/2999
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00014	(autopsy), gross examination only, stillborn of newborn with brain	Plan. Not subject to pre-service review.	1/1/1950	12/3 1/2999
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00010	(datopoy), gross oxamination only, massiated stillborn	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
88020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00020	(datopoy), gross and morescopic, marcat cive	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
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 brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		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. Not	9/1/2020	12/31/2999
	referred, each endoscopic session	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. Not	9/1/2020	12/31/2999
	referred, each endoscopic session	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	3/20/2018	12/31/2999
	-,,	Plan. Not subject to pre-service review.		1.2.3.7.2.3.3
89337	Cryopreservation, mature oocyte(s)	Non Covered: Procedure/service not covered by the	1/1/2019	12/31/2999
		Plan. Not subject to pre-service review.		
89342	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.		
89343	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.		
89344	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.		
89346	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.		
89352	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.		
89353	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.		
89354	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.		
89356	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.		
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	use, 50 mg, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free,	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	for intramuscular use	Plan. Not subject to pre-service review.		
90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	intramuscular use	Plan. Not subject to pre-service review.		
90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular	Non Covered: Procedure/service not covered by the	7/1/2010	12/31/2999
	use	Plan. Not subject to pre-service review.		
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular	Non Covered: Procedure/service not covered by the	1/1/2024	5/31/2024
	luse	Plan. Not subject to pre-service review.		

90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
00001	including cortical mapping, motor threshold determination, delivery and	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	management	Clinical Review to avoid post-service review.		
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
00000	subsequent delivery and management, per session	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	Subsequent delivery and management, per seconom	Clinical Review to avoid post-service review.		
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
00000	subsequent motor threshold re-determination with delivery and management	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	Subsequent motor threshold re-determination with delivery and management	Clinical Review to avoid post-service review.		
90875	Individual psychophysiological therapy incorporating biofeedback training by any	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
00010		Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	behavior modifying or supportive psychotherapy); 30 minutes	Clinical Review to avoid post-service review.		
90876		MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
30070		Medical Policy Criteria. Submit for Recommended	1/1/2000	12/31/2999
		Clinical Review to avoid post-service review.		
90880	behavior modifying or supportive psychotherapy); 45 minutes	MP Criteria: Procedure/service reviewed against	1/1/1950	5/31/2024
90000	Hypnotherapy	_	1/1/1950	3/31/2024
İ		Medical Policy Criteria. Submit for Recommended		
00005	Doubistic control to the control of	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	and/or projective tests, and other accumulated data for medical diagnostic purposes	Plan. Not subject to pre-service review.		
90889	Preparation of report of patient's psychiatric status, history, treatment, or	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	progress (other than for legal or consultative purposes) for other individuals,	Plan. Not subject to pre-service review.		
	agencies, or insurance carriers	, i		
90901	Biofeedback training by any modality	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.		
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	EMG and/or manometry, when performed; initial 15 minutes of one-on-one	Medical Policy Criteria. Submit for Recommended		
	physician or other qualified health care professional contact with the patient	Clinical Review to avoid post-service review.		
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including		4/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	(List separately in addition to code for primary procedure)	onlinear review to avoid post service review.		
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose	FILL: Procedure/service not reimbursed by the Plan Not	12/1/2020	12/31/2999
01000	intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	intolerance, bacterial evergrowth, or ore-occar gastronnestinal transity	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose		12/1/2020	12/31/2999
91003	intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
	intolerance, bacterial overgrowth, or oro-cecal gastrolinestinal transity			
		is one of our Clinical Payment and Coding Policy		
01110		(CPCP).	4/4/4050	40/04/0000
91110		MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	through ileum, with interpretation and report	Medical Policy Criteria. Submit for Recommended		
01111		Clinical Review to avoid post-service review.	1011100	10/04/006
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	with interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	with interpretation and report	subject to pre-service review. Check EIU policy, which	, ,,	1.2.0.200
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91112	Gastrointestinal transit and pressure measurement, stomach through colon,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	wireless capsule, with interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91112	Gastrointestinal transit and pressure measurement, stomach through colon,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	wireless capsule, with interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04440		(CPCP).	4/4/0000	10/04/0000
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
91117		(CPCP). MP Criteria: Procedure/service reviewed against	11/15/2023	40/04/0000
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension,	Medical Policy Criteria. Submit for Recommended	11/15/2023	12/31/2999
91132	pharmacologic agents, if performed), with interpretation and report Electrogastrography, diagnostic, transcutaneous;	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
91132	Liectrogastrography, diagnostic, transcutaneous,	subject to pre-service review. Check EIU policy, which	9/1/2020	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
2222		(CPCP).	1.1.1.100.10	10/01/0000
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
00400	professional	Plan. Not subject to pre-service review.	0/4/0000	10/01/0000
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	interpretation and report, unilateral or bilateral	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
92132	Coopping computarized arbtholmic diagnostic imaging enterior as arrest with	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with		9/1/2020	12/3 1/2999
	interpretation and report, unilateral or bilateral	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
32 140	bilateral, with interpretation and report	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2333
	bilateral, with interpretation and report	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	bilateral, with interpretation and report	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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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 and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; cervical (cVEMP)	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 and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; cervical (cVEMP)	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 and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; ocular (oVEMP)	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 and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; ocular (oVEMP)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00540		(CPCP).	- / / - / O O O /	10/04/0000
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; cervical (cVEMP) and ocular (oVEMP)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00540	\( \langle    \langle \text{   \text{   \langle \text{   \langle \text{   \text{   \langle \text{   \langle \text{   \langle \text{   \t	(CPCP).	E/4E/0004	40/04/0000
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	report; cervical (cVEMP) and ocular (oVEMP)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00540	Committee and the committee an	(CPCP).	40/4/0000	40/04/0000
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed	subject to pre-service review. Check EIU policy, which		
	platform sway, platform and visual sway), including interpretation and report;	is one of our Clinical Payment and Coding Policy		
00540	0	(CPCP).	40/4/0000	40/04/0000
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed	subject to pre-service review. Check EIU policy, which		
	platform sway, platform and visual sway), including interpretation and report;	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
32343	conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
	platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)	(CPCP).		
92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed	subject to pre-service review. Check EIU policy, which		
	platform sway, platform and visual sway), including interpretation and report; with			
	motor control test (MCT) and adaptation test (ADT)	(CPCP).		
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 (List	Medical Policy Criteria. Submit for Recommended		
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	code for primary procedure)	Medical Policy Criteria. Submit for Recommended		1-7-7-1-1-1-1
	bodo for primary procedure)	Clinical Review to avoid post-service review.		
93050	Arterial pressure waveform analysis for assessment of central arterial pressures,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
33030	includes obtaining waveform(s), digitization and application of nonlinear	subject to pre-service review. Check EIU policy, which	3/ 1/2020	12/01/2000
	mathematical transformations to determine central arterial pressures and	is one of our Clinical Payment and Coding Policy		
	augmentation index, with interpretation and report, upper extremity artery, non-	(CPCP).		
00050	invasive	FILL December 1 and a section between the the Disc. Not	0/4/0000	40/04/0000
93050	Arterial pressure waveform analysis for assessment of central arterial pressures,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	includes obtaining waveform(s), digitization and application of nonlinear	subject to pre-service review. Check EIU policy, which		
	mathematical transformations to determine central arterial pressures and	is one of our Clinical Payment and Coding Policy		
	augmentation index, with interpretation and report, upper extremity artery, non- invasive	(CPCP).		
93150	Therapy activation of implanted phrenic nerve stimulator system, including all	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	interrogation and programming	subject to pre-service review. Check EIU policy, which		
	Interrogation and programming	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
93150	Therapy activation of implanted phrenic nerve stimulator system, including all	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	interrogation and programming	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, including all	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	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 phrenic	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	nerve stimulator system	subject to pre-service review. Check EIU policy, which		12,5 ., 2555
	norto santalator oyotom	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
93151	Interrogation and programming (minimum one parameter) of implanted phrenic	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	nerve stimulator system	subject to pre-service review. Check EIU policy, which		12,5 ., 2555
	no 15 difficiation by bloth	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
02151	Interrogation and programming (minimum one parameter) of implanted phrenic	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
93151		_	2/13/2024	3/ 14/2024
	nerve stimulator system	Medical Policy Criteria. Submit for Recommended		
	<u>_</u>	Clinical Review to avoid post-service review.	<u> </u>	1

93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
93153	Interrogation without programming of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93153	Interrogation without programming of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
93153	Interrogation without programming of implanted phrenic nerve stimulator system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2005	12/31/2999
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
00102	assessment(s)	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	assessment(s)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
93740	Temperature gradient studies	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
93740	Temperature gradient studies	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
94014	Patient-initiated spirometric recording per 30-day period of time; includes	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	reinforced education, transmission of spirometric tracing, data capture, analysis	subject to pre-service review. Check EIU policy, which		
	of transmitted data, periodic recalibration and review and interpretation by a	is one of our Clinical Payment and Coding Policy		
	physician or other qualified health care professional	(CPCP).		
94014	Patient-initiated spirometric recording per 30-day period of time; includes	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	reinforced education, transmission of spirometric tracing, data capture, analysis	subject to pre-service review. Check EIU policy, which		
	of transmitted data, periodic recalibration and review and interpretation by a	is one of our Clinical Payment and Coding Policy		
0.10.15	physician or other qualified health care professional	(CPCP).	0/4/0000	10/01/0000
94015	Patient-initiated spirometric recording per 30-day period of time; recording	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	(includes hook-up, reinforced education, data transmission, data capture, trend	subject to pre-service review. Check EIU policy, which		
	analysis, and periodic recalibration)	is one of our Clinical Payment and Coding Policy		
94015	Patient-initiated spirometric recording per 30-day period of time; recording	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
94015	(includes hook-up, reinforced education, data transmission, data capture, trend	subject to pre-service review. Check EIU policy, which	9/1/2020	12/31/2999
	analysis, and periodic recalibration)	is one of our Clinical Payment and Coding Policy		
	analysis, and periodic recalibration)	(CPCP).		
94016	Patient-initiated spirometric recording per 30-day period of time; review and	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	interpretation only by a physician or other qualified health care professional	subject to pre-service review. Check EIU policy, which		12.01.200
	morphotation strip all a proposition of strip qualified from the proposition	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
94016	Patient-initiated spirometric recording per 30-day period of time; review and	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	interpretation only by a physician or other qualified health care professional	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
94452	High altitude simulation test (HAST), with interpretation and report by a physician		1/1/2005	12/31/2999
	or other qualified health care professional;	Plan. Not subject to pre-service review.		
94453	High altitude simulation test (HAST), with interpretation and report by a physician	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	or other qualified health care professional; with supplemental oxygen titration	Plan. Not subject to pre-service review.		
0.5000			10/1/0000	10/01/0000
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
05000	Out the desire and a second second to the	(CPCP).	40/4/0000	10/04/0000
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

95065	Direct nasal mucous membrane test	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		12.5 11.2 11.2
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
95065	Direct nasal mucous membrane test	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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 performed,	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	by EEG technologist, minimum of 8 channels	Clinical Review to avoid post-service review.		
95705	Electroencephalogram (EEG), without video, review of data, technical description		11/1/2023	12/31/2999
	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 description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95707	Electroencephalogram (EEG), without video, review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, 2-12 hours; with continuous, real-time monitoring and	Medical Policy Criteria. Submit for Recommended		
	maintenance	Clinical Review to avoid post-service review.		
95708	Electroencephalogram (EEG), without video, review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, each increment of 12-26 hours; unmonitored	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95709	Electroencephalogram (EEG), without video, review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, each increment of 12-26 hours; with intermittent monitoring	Medical Policy Criteria. Submit for Recommended		
	and maintenance	Clinical Review to avoid post-service review.		
95710	Electroencephalogram (EEG), without video, review of data, technical description		11/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	monitoring and maintenance	Clinical Review to avoid post-service review.		
95711	Electroencephalogram with video (VEEG), review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	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 description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95713	Electroencephalogram with video (VEEG), review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, 2-12 hours; with continuous, real-time monitoring and	Medical Policy Criteria. Submit for Recommended		
	maintenance	Clinical Review to avoid post-service review.		
95714		MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, each increment of 12-26 hours; unmonitored	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95715	Electroencephalogram with video (VEEG), review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, each increment of 12-26 hours; with intermittent monitoring			
	and maintenance	Clinical Review to avoid post-service review.		
95716	Electroencephalogram with video (VEEG), review of data, technical description	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	by EEG technologist, each increment of 12-26 hours; with continuous, real-time	Medical Policy Criteria. Submit for Recommended		
	monitoring and maintenance	Clinical Review to avoid post-service review.		

95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
		Clinical Review to avoid post-service review.		
95718	health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95719	health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95720	health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95721	health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2023	12/31/2999
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
95803	•	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	9/30/2024

95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
55505	amplitude and latency/velocity study, each limb, includes F-wave study when	subject to pre-service review. Check EIU policy, which	3/1/2020	12/3 1/2333
	performed, with interpretation and report	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	amplitude and latency/velocity study, each limb, includes F-wave study when	subject to pre-service review. Check EIU policy, which		
	performed, with interpretation and report	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. Not	1/1/2023	12/31/2999
	professional interpretation and report, unilateral or bilateral	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		12/2/22
95919	Quantitative pupillometry with physician or other qualified health care	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	professional interpretation and report, unilateral or bilateral	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.5054		(CPCP).	4.4.4.40000	10/01/0000
95954	Pharmacological or physical activation requiring physician or other qualified	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
	health care professional attendance during EEG recording of activation phase	Medical Policy Criteria. Submit for Recommended		
	(eg, thiopental activation test)	Clinical Review to avoid post-service review.	4.4.4.40000	10/01/0000
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	MP Criteria: Procedure/service reviewed against	11/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
05004		Clinical Review to avoid post-service review.	0/4/0004	10/04/0000
95961	Functional cortical and subcortical mapping by stimulation and/or recording of	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	electrodes on brain surface, or of depth electrodes, to provoke seizures or	Medical Policy Criteria. Submit for Recommended		
	identify vital brain structures; initial hour of attendance by a physician or other	Clinical Review to avoid post-service review.		
05000	qualified health care professional	MD Criteria: Dress dure/s amiss reviseured a reinst	3/1/2024	40/04/0000
95962	Functional cortical and subcortical mapping by stimulation and/or recording of	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	electrodes on brain surface, or of depth electrodes, to provoke seizures or	Medical Policy Criteria. Submit for Recommended		
	identify vital brain structures; each additional hour of attendance by a physician	Clinical Review to avoid post-service review.		
	or other qualified health care professional (List separately in addition to code for			
95965	primary procedure)  Magnetoencephalography (MEG), recording and analysis; for spontaneous brain	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
95905	magnetic activity (eg, epileptic cerebral cortex localization)	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/3 1/2999
	Imagnetic activity (eg, epileptic cerebral cortex localization)	Clinical Review to avoid post-service review.		
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
93900	fields, single modality (eg, sensory, motor, language, or visual cortex localization)		4/1/2009	12/31/2999
	inelds, single modality (eg, sensory, motor, language, or visual cortex localization)	Clinical Review to avoid post-service review.		
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
55501	fields, each additional modality (eg, sensory, motor, language, or visual cortex	Medical Policy Criteria. Submit for Recommended	4/ 1/2003	12/3 1/2333
	localization) (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	rate, pulse amplitude and duration, configuration of wave form, battery status,	Medical Policy Criteria. Submit for Recommended	1 2000	10.,-000
	electrode selectability, output modulation, cycling, impedance and patient	Clinical Review to avoid post-service review.		
	measurements) gastric neurostimulator pulse generator/transmitter; subsequent,			
	without reprogramming			
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	rate, pulse amplitude and duration, configuration of wave form, battery status,	Medical Policy Criteria. Submit for Recommended		
	electrode selectability, output modulation, cycling, impedance and patient	Clinical Review to avoid post-service review.		
	measurements) gastric neurostimulator pulse generator/transmitter; subsequent,			
	with reprogramming			
	Ima reprogramming	1	1	

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 activities,	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	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 activities,	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	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 professional	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	of comprehensive computer-based motion analysis, dynamic plantar pressure	Medical Policy Criteria. Submit for Recommended		
	measurements, dynamic surface electromyography during walking or other	Clinical Review to avoid post-service review.		
	functional activities, and dynamic fine wire electromyography, with written report	'		
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	including separate incision(s) and closure, when performed; 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) procedure,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	including separate incision(s) and closure, when performed; each additional 30	Medical Policy Criteria. Submit for Recommended		
	minutes (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	tissue via activation of photosensitive drug(s); each additional 15 minutes (List	Medical Policy Criteria. Submit for Recommended	., ., .,	12/3 //2000
	separately in addition to code for endoscopy or bronchoscopy procedures of lung			
	and gastrointestinal tract)	ominoar review to avoid poor corvice review.		
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 photoresponsive	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	dermatoses requiring at least 4-8 hours of care under direct supervision of the	Medical Policy Criteria. Submit for Recommended		
	physician (includes application of medication and dressings)	Clinical Review to avoid post-service review.		
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
	3 3,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97546	Work hardening/conditioning; each additional hour (List separately in addition to	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
	Joseph Marian J. Procedure J.	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. Not	9/1/2020	12/31/2999
	application(s), when performed, wound assessment, and instruction(s) for	subject to pre-service review. Check EIU policy, which		
	ongoing care, per day	is one of our Clinical Payment and Coding Policy		
	5g 5g, por day	(CPCP).		
97610	Low frequency, non-contact, non-thermal ultrasound, including topical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	application(s), when performed, wound assessment, and instruction(s) for	subject to pre-service review. Check EIU policy, which		12,0 1,200
	ongoing care, per day	is one of our Clinical Payment and Coding Policy		
	ongoing sare, per day	(CPCP).		

97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	2/29/2024
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99075	Medical testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99082	Unusual travel (eg, transportation and escort of patient)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99360	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates.		1/1/1950	12/31/2999
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.		1/1/1950	12/31/2999
99509	Home visit for assistance with activities of daily living and personal care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins,	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2018	12/31/2999
00320	including all five major lipoprotein classes and subclasses of HDL, LDL, and	subject to pre-service review. Check EIU policy, which	17 1/2010	12/31/2999
	VLDL by vertical auto profile ultracentrifugation	is one of our Clinical Payment and Coding Policy		
	VEDE by Vertical auto profile diffacentingation	(CPCP).		
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins,	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2018	12/31/2999
	including all five major lipoprotein classes and subclasses of HDL, LDL, and	subject to pre-service review. Check EIU policy, which		
	VLDL by vertical auto profile ultracentrifugation	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	with image-guidance based on fluoroscopic images (List separately in addition to			
	code for primary procedure)	is one of our Clinical Payment and Coding Policy		
0054T		(CPCP).	0/4/0000	40/04/0000
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	with image-guidance based on fluoroscopic images (List separately in addition to			
	code for primary procedure)	is one of our Clinical Payment and Coding Policy		
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
00331	with image-guidance based on CT/MRI images (List separately in addition to	subject to pre-service review. Check EIU policy, which	9/ 1/2020	12/3 1/2999
	code for primary procedure)	is one of our Clinical Payment and Coding Policy		
	code for primary procedure)	(CPCP).		
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	with image-guidance based on CT/MRI images (List separately in addition to	subject to pre-service review. Check EIU policy, which		1-7-3-7-3-3
	code for primary procedure)	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. Not	12/1/2020	12/31/2999
	biomarkers, utilizing serum, algorithm reported with a risk score	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80		12/1/2020	12/31/2999
	biomarkers, utilizing serum, algorithm reported with a risk score	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0063U	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	as metabolic signature associated with autism spectrum disorder	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0063U	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
00030	as metabolic signature associated with autism spectrum disorder	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
	as metabolic signature associated with autism spectrum disorder	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance;	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	total leiomyomata volume less than 200 cc of tissue	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance;	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	total leiomyomata volume greater or equal to 200 cc of tissue	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
	radiologic supervision and interpretation, open or percutaneous; initial vessel	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

0076T	Transcatheter placement of extracranial vertebral artery stent(s), including	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
	radiologic supervision and interpretation, open or percutaneous; each additional	Medical Policy Criteria. Submit for Recommended		
	vessel (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	and implantation of intraocular retinal electrode array, with vitrectomy	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	9/14/2024
	and implantation of intraocular retinal electrode array, with vitrectomy	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0404T	F. 4	(CPCP).	0/4/0000	40/04/0000
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	specified	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
01011	specified	subject to pre-service review. Check EIU policy, which	9/1/2020	12/31/2999
	3peomed	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other	FIU: Procedure/service not reimbursed by the Plan Not	9/1/2020	12/31/2999
	than local, and involving the lateral humeral epicondyle	subject to pre-service review. Check EIU policy, which	0, 1,2020	12/5 //2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	than local, and involving the lateral humeral epicondyle	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent	MP Criteria: Procedure/service reviewed against	10/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with	Clinical Review to avoid post-service review.		
	longitudinal clinical data, including APOL1 genotype if available, and plasma			
	(isolated fresh or frozen), algorithm reported as probability score for rapid kidney			
04007	function decline (RKFD)		0/4/0000	10/04/0000
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using		9/1/2020	12/31/2999
	touch pressure stimuli to assess large diameter sensation	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using	(CPCP).	9/1/2020	12/31/2999
0.001	touch pressure stimuli to assess large diameter sensation	subject to pre-service review. Check EIU policy, which	0/ 1/2020	12/01/2009
	touch prossure sumun to assess large diameter sensation	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope		12/1/2020	12/31/2999
	carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope	subject to pre-service review. Check EIU policy, which		, , , , , , , , , , , , , , , , , , , ,
	ratio mass spectrometry, reported as rate of 13CO2 excretion	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope		12/1/2020	12/31/2999
	carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope	subject to pre-service review. Check EIU policy, which		
	ratio mass spectrometry, reported as rate of 13CO2 excretion	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using	FILL: Procedure/service not reimbursed by the Plan Not	9/1/2020	12/31/2999
01071	vibration stimuli to assess large diameter fiber sensation	subject to pre-service review. Check EIU policy, which	3/ 1/2020	12/3 1/2333
	vibration stillar to assess large diameter liber schedulen	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using		9/1/2020	12/31/2999
	vibration stimuli to assess large diameter fiber sensation	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 extremity; using		9/1/2020	12/31/2999
	cooling stimuli to assess small nerve fiber sensation and hyperalgesia	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using	(CPCP).	0/4/2020	12/31/2999
01001	cooling stimuli to assess small nerve fiber sensation and hyperalgesia	subject to pre-service review. Check EIU policy, which	9/1/2020	12/3 1/2999
	cooling stilliuli to assess striali herve liber serisation and hyperalgesia	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using		9/1/2020	12/31/2999
01001	heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	subject to pre-service review. Check EIU policy, which	0/1/2020	12/01/2000
	Thous paint carried to access strict horror had contoured and hypotalysola	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	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 extremity; using		9/1/2020	12/31/2999
	other stimuli to assess sensation	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.1.10=		(CPCP).	01110000	10/01/0000
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using		9/1/2020	12/31/2999
	other stimuli to assess sensation	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
01301	with interpretation and report	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
	with interpretation and report	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	with interpretation and report	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), including		11/1/2019	12/31/2999
	the use of a balloon or mechanical device, when used, 1 or more needles,	Medical Policy Criteria. Submit for Recommended		
	includes imaging guidance and bone biopsy, when performed	Clinical Review to avoid post-service review.		
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	the use of a balloon or mechanical device, when used, 2 or more needles,	Medical Policy Criteria. Submit for Recommended		
0000T	includes imaging guidance and bone biopsy, when performed	Clinical Review to avoid post-service review.	40/4/0000	40/24/2000
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including		12/1/2020	12/31/2999
	facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection			
	of bone cement, when performed, including fluoroscopy, single level, lumbar	is one of our Clinical Payment and Coding Policy		
	spine	(CPCP).		

0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
02021	facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection		12/1/2020	12/3 1/2333
	of bone cement, when performed, including fluoroscopy, single level, lumbar	is one of our Clinical Payment and Coding Policy		
	spine	(CPCP).		
0207T	Evacuation of meibomian glands, automated, using heat and intermittent	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
02011	pressure, unilateral	subject to pre-service review. Check EIU policy, which	0, 1,2020	12,01,200
		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. Not	9/1/2020	12/31/2999
	pressure, unilateral	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, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	cervical	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	cervical	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	thoracic	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	thoracic	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	lumbar	is one of our Clinical Payment and Coding Policy		
00047		(CPCP).	40/4/0000	40/04/0000
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	imaging and placement of bone graft(s) or synthetic device(s), single level;	subject to pre-service review. Check EIU policy, which		
	lumbar	is one of our Clinical Payment and Coding Policy (CPCP).		
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
02221		subject to pre-service review. Check EIU policy, which	12/1/2020	12/3/1/2333
	additional vertebral segment (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
V		subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	additional vertebral segment (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	(Coronavirus disease [COVID-19]), includes titer(s), when performed	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-2)	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
02240	(Coronavirus disease [COVID-19]), includes titer(s), when performed	subject to pre-service review. Check EIU policy, which	0/1/2023	12/31/2999
	(Colonavirus disease [COVID-19]), includes titel(s), when periorned	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma,			
	seru	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma,			
	seru	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	and preparation when performed	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, harvesting	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	and preparation when performed	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).	4440044	10/04/0000
0253T	Insertion of anterior segment aqueous drainage device, without extraocular	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	reservoir, internal approach, into the suprachoroidal space	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	01110000	10/01/0000
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which		
	performed; complete procedure including unilateral or bilateral bone marrow	is one of our Clinical Payment and Coding Policy		
<del>-</del>	harvest	(CPCP).	0///0000	10/01/0000
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which		
	performed; complete procedure including unilateral or bilateral bone marrow	is one of our Clinical Payment and Coding Policy		
0064T	harvest Intramuscular autologous bone marrow cell therapy, with preparation of	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	0/4/2020	12/31/2999
0264T			9/1/2020	12/3 1/2999
	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which		
	performed; complete procedure excluding bone marrow harvest	is one of our Clinical Payment and Coding Policy		
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
020 <del>4</del> I	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which	9/1/2020	12/31/2999
	performed; complete procedure excluding bone marrow harvest	is one of our Clinical Payment and Coding Policy		
	performed, complete procedure excluding bone marrow harvest	(CPCP).		
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
02001	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which	0/1/2020	12/01/2000
	performed; unilateral or bilateral bone marrow harvest only for intramuscular	is one of our Clinical Payment and Coding Policy		
	autologous bone marrow cell therapy	(CPCP).		
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	harvested cells, multiple injections, one leg, including ultrasound guidance, if	subject to pre-service review. Check EIU policy, which		
	performed; unilateral or bilateral bone marrow harvest only for intramuscular	is one of our Clinical Payment and Coding Policy		
	autologous bone marrow cell therapy	(CPCP).		
0266T	Implantation or replacement 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 placement,	Medical Policy Criteria. Submit for Recommended		
	intra-operative interrogation, programming, and repositioning, when performed)	Clinical Review to avoid post-service review.	Ī	

0267T	Implantation or replacement 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		12,01,200
	repositioning, when performed)	Clinical Review to avoid post-service review.		
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse	MP Criteria: Procedure/service reviewed against	8/16/2019	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.		
0269T	Revision or removal of carotid sinus baroreflex activation device; total system	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	(includes generator placement, unilateral or bilateral lead placement, intra-	Medical Policy Criteria. Submit for Recommended		
	operative interrogation, programming, and repositioning, when performed)	Clinical Review to avoid post-service review.		
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only,	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	unilateral (includes intra-operative interrogation, programming, and repositioning,			
	when performed)	Clinical Review to avoid post-service review.		
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	only (includes intra-operative interrogation, programming, and repositioning,	Medical Policy Criteria. Submit for Recommended		
	when performed)	Clinical Review to avoid post-service review.		
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
l	system, including telemetric iterative communication with the implantable device	Medical Policy Criteria. Submit for Recommended		
	to monitor device diagnostics and programmed therapy values, with	Clinical Review to avoid post-service review.		
	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 activation	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	system, including telemetric iterative communication with the implantable device	Medical Policy Criteria. Submit for Recommended		
	to monitor device diagnostics and programmed therapy values, with	Clinical Review to avoid post-service review.		
	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. Not	1/1/2023	12/31/2999
	decompression of neural elements, (with or without ligamentous resection,	subject to pre-service review. Check EIU policy, which		
	discectomy, facetectomy and/or foraminotomy), any method, under indirect	is one of our Clinical Payment and Coding Policy		
	image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or	(CPCP).		
	bilateral; cervical or thoracic			
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	decompression of neural elements, (with or without ligamentous resection,	subject to pre-service review. Check EIU policy, which		
	discectomy, facetectomy and/or foraminotomy), any method, under indirect	is one of our Clinical Payment and Coding Policy		
	image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or	(CPCP).		
	bilateral; cervical or thoracic		4440000	10/04/0000
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	decompression of neural elements, (with or without ligamentous resection,	subject to pre-service review. Check EIU policy, which		
	discectomy, facetectomy and/or foraminotomy), any method, under indirect	is one of our Clinical Payment and Coding Policy		
	image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or	(CPCP).		
00757	bilateral; lumbar	Fills Dressed me/semiles not nainshansed by the Dien Net	4/4/2022	40/24/2000
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	decompression of neural elements, (with or without ligamentous resection,	subject to pre-service review. Check EIU policy, which		
	discectomy, facetectomy and/or foraminotomy), any method, under indirect	is one of our Clinical Payment and Coding Policy		
	image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or	(CPCP).		
	bilateral; lumbar			

0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy),	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
02701	each treatment session (includes placement of electrodes)	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	leach treatment session (includes placement of electrodes)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy),	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	each treatment session (includes placement of electrodes)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or	MP Criteria: Procedure/service reviewed against	7/1/2012	12/31/2999
	intraocular lens prosthesis	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14	EIU: Procedure/service not reimbursed by the Plan. Not	1/15/2024	12/31/2999
	acyl carnitines and microbiome-derived metabolites, liquid chromatography with	subject to pre-service review. Check EIU policy, which		
	tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or	is one of our Clinical Payment and Coding Policy		
	positive for risk of metabolic subtypes associated with ASD	(CPCP).		
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14	EIU: Procedure/service not reimbursed by the Plan. Not	1/15/2024	12/31/2999
	acyl carnitines and microbiome-derived metabolites, liquid chromatography with	subject to pre-service review. Check EIU policy, which		
	tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or	is one of our Clinical Payment and Coding Policy		
	positive for risk of metabolic subtypes associated with ASD	(CPCP).		
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14	MP Criteria: Procedure/service reviewed against	10/15/2023	1/14/2024
	acyl carnitines and microbiome-derived metabolites, liquid chromatography with	Medical Policy Criteria. Submit for Recommended		
	tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or	Clinical Review to avoid post-service review.		
	positive for risk of metabolic subtypes associated with ASD			
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	assessment;	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	assessment; with tomographic SPECT	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0335T	Insertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		12121222
0335T	Insertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00007	T	(CPCP).	0/4/0000	140/04/0000
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy,	subject to pre-service review. Check EIU policy, which		
	contrast injection(s), intraprocedural roadmapping and radiological supervision	is one of our Clinical Payment and Coding Policy		
	and interpretation, including pressure gradient measurements, flush aortogram	(CPCP).		
	and diagnostic renal angiography when performed; unilateral			

0338T	Transcatheter renal sympathetic denervation, percutaneous approach including	EIU: Procedure/service not reimbursed by the Plan. Not	0/1/2020	12/31/2999
00001	arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy,	subject to pre-service review. Check EIU policy, which	3/1/2020	12/3 1/2999
	contrast injection(s), intraprocedural roadmapping and radiological supervision	is one of our Clinical Payment and Coding Policy		
	and interpretation, including pressure gradient measurements, flush aortogram	(CPCP).		
0220T	and diagnostic renal angiography when performed; unilateral	FILL Draggedurg/garding not raimburged by the Dian Not	0/4/2020	12/31/2999
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy,	subject to pre-service review. Check EIU policy, which		
	contrast injection(s), intraprocedural roadmapping and radiological supervision	is one of our Clinical Payment and Coding Policy		
	and interpretation, including pressure gradient measurements, flush aortogram	(CPCP).		
	and diagnostic renal angiography when performed; bilateral		0/4/0000	10/01/0000
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy,	subject to pre-service review. Check EIU policy, which		
	contrast injection(s), intraprocedural roadmapping and radiological supervision	is one of our Clinical Payment and Coding Policy		
	and interpretation, including pressure gradient measurements, flush aortogram	(CPCP).		
	and diagnostic renal angiography when performed; bilateral			
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	cervical, thoracic and lumbosacral, when performed)	subject to pre-service review. Check EIU policy, which		1
	John House, and half	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	cervical, thoracic and lumbosacral, when performed)	subject to pre-service review. Check EIU policy, which		1
	John House, and half	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
00101	(includes shoulder, elbow, and wrist, when performed)	subject to pre-service review. Check EIU policy, which	0/ 1/2020	12/01/2000
	(morados sindados, distaw, and whot, whom performed)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
00401	(includes shoulder, elbow, and wrist, when performed)	subject to pre-service review. Check EIU policy, which	0/ 1/2020	12/01/2009
	(includes shoulder, elbow, and what, when performed)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
00001		subject to pre-service review. Check EIU policy, which	3/ 1/2020	12/31/2999
	(includes hip, proximal femur, knee, and ankle, when performed)			
		is one of our Clinical Payment and Coding Policy		
0250T	Dediclosic exemination, radicators are this analysis (DCA), laws a strong to (to a)	(CPCP).	0/4/2020	12/21/2000
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies),	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	(includes hip, proximal femur, knee, and ankle, when performed)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	12/1/2020	12/31/2999
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	endomicroscopy (List separately in addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS),	MP Criteria: Procedure/service reviewed against	3/1/2020	12/31/2999
	stereotactic ablation lesion, intracranial for movement disorder including	Medical Policy Criteria. Submit for Recommended		
	stereotactic navigation and frame placement when performed	Clinical Review to avoid post-service review.		
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium,	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
	when performed, and intraoperative pachymetry, when performed	Medical Policy Criteria. Submit for Recommended		
		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	Medical Policy Criteria. Submit for Recommended		
	receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney	Clinical Review to avoid post-service review.		
	injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported	· ·		
l	as risk for progressive decline in kidney function			
0408T	Insertion or replacement of permanent cardiac contractility modulation system,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
I	including contractility evaluation when performed, and programming of sensing	Medical Policy Criteria. Submit for Recommended		
	and therapeutic parameters; pulse generator with transvenous electrodes	Clinical Review to avoid post-service review.		
0409T	Insertion or replacement of permanent cardiac contractility modulation system,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	including contractility evaluation when performed, and programming of sensing	Medical Policy Criteria. Submit for Recommended		
	and therapeutic parameters; pulse generator only	Clinical Review to avoid post-service review.		
0410T	Insertion or replacement of permanent cardiac contractility modulation system,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	including contractility evaluation when performed, and programming of sensing	Medical Policy Criteria. Submit for Recommended		
	and therapeutic parameters; atrial electrode only	Clinical Review to avoid post-service review.		
0411T	Insertion or replacement of permanent cardiac contractility modulation system,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	including contractility evaluation when performed, and programming of sensing	Medical Policy Criteria. Submit for Recommended		
	and therapeutic parameters; ventricular electrode only	Clinical Review to avoid post-service review.		
0412T	Removal of permanent cardiac contractility modulation system; pulse generator	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	only	Medical Policy Criteria. Submit for Recommended		
	'	Clinical Review to avoid post-service review.		
0413T	Removal of permanent cardiac contractility modulation system; transvenous	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	electrode (atrial or ventricular)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0414T	Removal and replacement of permanent cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	pulse generator only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0415T	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		
	,	Clinical Review to avoid post-service review.		
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	generator	Medical Policy Criteria. Submit for Recommended		
	ľ	Clinical Review to avoid post-service review.		
0417T	Programming device evaluation (in person) with iterative adjustment of the	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	implantable device to test the function of the device and select optimal	Medical Policy Criteria. Submit for Recommended		
	permanent programmed values with analysis, including review and report,	Clinical Review to avoid post-service review.		
	implantable cardiac contractility modulation system			
0418T	Interrogation device evaluation (in person) with analysis, review and report,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
- I	includes connection, recording and disconnection per patient encounter,	Medical Policy Criteria. Submit for Recommended		
	implantable cardiac contractility modulation system	Clinical Review to avoid post-service review.		

0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
04221	Tablic broad imaging by compater alace tablic sorious, annatoral or bilateral	Medical Policy Criteria. Submit for Recommended	11/1/2010	12/01/2000
		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
04401	extremity distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended	0/1/2024	12/01/2000
	extremity distal/peripheral herve	Clinical Review to avoid post-service review.		
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended	,	1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	allow, portprioral morro	Clinical Review to avoid post-service review.		
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	other truncal nerve (eg. brachial plexus, pudendal nerve)	Medical Policy Criteria. Submit for Recommended		
	, p,	Clinical Review to avoid post-service review.		
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	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, internal	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
l	approach, into the subconjunctival space; each additional device (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 report	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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 report	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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 retinal	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the	subject to pre-service review. Check EIU policy, which		
	implantable device to test functionality, select optimal permanent programmed	is one of our Clinical Payment and Coding Policy		
	values with analysis, including visual training, with review and report by a	(CPCP).		
	qualified health care professional			
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	9/14/2024
	electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the			
	implantable device to test functionality, select optimal permanent programmed	is one of our Clinical Payment and Coding Policy		
	values with analysis, including visual training, with review and report by a	(CPCP).		
	qualified health care professional			
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	retinal prosthesis), in person, including reprogramming and visual training, when	subject to pre-service review. Check EIU policy, which		
	performed, with review and report by a qualified health care professional	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	9/14/2024
	retinal prosthesis), in person, including reprogramming and visual training, when	subject to pre-service review. Check EIU policy, which		
	performed, with review and report by a qualified health care professional	is one of our Clinical Payment and Coding 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	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
I	improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants	Medical Policy Criteria. Submit for Recommended		
	and children	Clinical Review to avoid post-service review.		

0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	·	11/1/2019	12/31/2999
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0507T	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

0507T	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	of meibomian glands, unilateral or bilateral, with interpretation and report	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	0, 1,2020	1.2.6 %2666
0500T	Floring the second of CDO) with intermediation and second on the CDCO	(CPCP).	E/4E/0004	40/04/0000
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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 topical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	application and dressing care; initial wound	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 topical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	application and dressing care; initial wound	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0513T	Extracorporeal shock wave for integumentary wound healing, including topical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	application and dressing care; each additional wound (List separately in addition	subject to pre-service review. Check EIU policy, which		
	to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
	, , , ,	(CPCP).		
0513T	Extracorporeal shock wave for integumentary wound healing, including topical	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
	to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device		10/1/2019	12/31/2999
	interrogation and programming, and imaging supervision and interpretation,	Medical Policy Criteria. Submit for Recommended		
	when performed; electrode only	Clinical Review to avoid post-service review.		
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device		10/1/2019	12/31/2999
	interrogation and programming, and imaging supervision and interpretation,	Medical Policy Criteria. Submit for Recommended		
	when performed; both components of pulse generator (battery and transmitter)	Clinical Review to avoid post-service review.		
	Ionly			
0524T	Endovenous catheter directed chemical ablation with balloon isolation of	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
	incompetent extremity vein, open or percutaneous, including all vascular access,	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
	catheter manipulation, diagnostic imaging, imaging guidance and monitoring	Clinical Review to avoid post-service review.		
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
	system with analysis, review, and report	Medical Policy Criteria. Submit for Recommended	, .,	12,5 1,255
	System that analysis, forton, and roport	Clinical Review to avoid post-service review.		
	l .	Ominous storiow to avoid post-solvide feview.	J	

0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
	lymphocytes for development of genetically modified autologous CAR-T cells,	Medical Policy Criteria. Submit for Recommended	0/10/2020	12/01/2000
	per day	Clinical Review to avoid post-service review.		
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
00001	lymphocytes for transportation (eg, cryopreservation, storage)	Medical Policy Criteria. Submit for Recommended	0/10/2020	12/01/2000
	lymphocytes for transportation (eg, cryopreservation, storage)	Clinical Review to avoid post-service review.		
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
00001	CAR-T cells for administration	Medical Policy Criteria. Submit for Recommended	0/13/2023	12/31/2999
	CAR-1 cells for administration			
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration,	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
03401		Medical Policy Criteria. Submit for Recommended	0/13/2023	12/3 1/2999
	autologous			
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable	Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
05441	· · · · · · · · · · · · · · · · · · ·		10/1/2022	12/31/2999
	annulus reconstruction device, percutaneous approach including transseptal	Medical Policy Criteria. Submit for Recommended		
05.45T	puncture	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	adjustable annulus reconstruction device, percutaneous approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	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 energies,	MP Criteria: Procedure/service reviewed against	12/15/2020	12/31/2999
	provided by a physician or other qualified health care professional	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	eye eyelid treatment devices and manual gland expression, bilateral	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, open-	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	eye eyelid treatment devices and manual gland expression, bilateral	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0565T	Autologous cellular implant derived from adipose tissue for the treatment of	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	osteoarthritis of the knees; tissue harvesting and cellular implant creation	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0565T	Autologous cellular implant derived from adipose tissue for the treatment of	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	osteoarthritis of the knees; tissue harvesting and cellular implant creation	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	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	osteoarthritis of the knees; injection of cellular implant into knee joint including	subject to pre-service review. Check EIU policy, which		1_,0 ,,_200
	ultrasound guidance, unilateral	is one of our Clinical Payment and Coding Policy		
	ana accurra guidanco, annatora	(CPCP).		
0566T	Autologous cellular implant derived from adipose tissue for the treatment of	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
00001	osteoarthritis of the knees; injection of cellular implant into knee joint including	subject to pre-service review. Check EIU policy, which	0, 10,2021	12/01/2009
	ultrasound guidance, unilateral	is one of our Clinical Payment and Coding Policy		
	ultrasouriu guluarioe, urillateral	(CPCP).		
		I(UFUF).		

0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Transcauloto alcaopia rairo ropan, poroalariocao approacii, iliniar procinciis	Medical Policy Criteria. Submit for Recommended	0, 1,2020	12/01/2000
		Clinical Review to avoid post-service review.		
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	prosthesis during same session (List separately in addition to code for primary	Medical Policy Criteria. Submit for Recommended	0, 1,2020	12/01/2000
	procedure)	Clinical Review to avoid post-service review.		
0587T	Percutaneous implantation or replacement of integrated single device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction including electrode array and	Medical Policy Criteria. Submit for Recommended	0, 1,202 1	12/01/2000
	receiver or pulse generator, including analysis, programming, and imaging	Clinical Review to avoid post-service review.		
	guidance when performed, posterior tibial nerve	Chillion review to avoid post sorvice review.		
0588T	Revision or removal of percutaneously placed integrated single device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction including electrode array and	Medical Policy Criteria. Submit for Recommended	0, 1,202 .	12/01/2000
	receiver or pulse generator, including analysis, programming, and imaging	Clinical Review to avoid post-service review.		
	guidance when performed, posterior tibial nerve	Officer Neview to avoid post-service review.		
0589T	Electronic analysis with simple programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
00001	neurostimulation system for bladder dysfunction (eg, electrode array and	Medical Policy Criteria. Submit for Recommended	0/ 1/2021	12/01/2000
İ	receiver), including contact group(s), amplitude, pulse width, frequency (Hz),	Clinical Review to avoid post-service review.		
	on/off cycling, burst, dose lockout, patient-selectable parameters, responsive	Cliffical Neview to avoid post-service review.		
	neurostimulation, detection algorithms, closed-loop parameters, and passive			
	parameters, when performed by physician or other qualified health care			
OFOOT	professional, posterior tibial nerve, 1-3 parameters	MD Criteria: Dragadura (samilas reviewad arrainat	3/1/2021	12/31/2999
0590T	Electronic analysis with complex programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction (eg, electrode array and	Medical Policy Criteria. Submit for Recommended		
	receiver), including contact group(s), amplitude, pulse width, frequency (Hz),	Clinical Review to avoid post-service review.		
	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			
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	insertion, including urethral measurement	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	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.		
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence,	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	location, and load, per session; first anatomic site (eg, lower extremity)	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,	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	location, and load, per session; first anatomic site (eg, lower extremity)	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. Not	10/1/2024	12/31/2999
	location, and load, per session; each additional anatomic site (eg, upper	subject to pre-service review. Check EIU policy, which		
	extremity) (List separately in addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		

0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2024	9/30/2024
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0615T	Eye-movement analysis without spatial calibration, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0615T	Eye-movement analysis without spatial calibration, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed		7/1/2024	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed		7/1/2024	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed		3/15/2024	6/30/2024

OCOOT	Fundamental process and a simple of the first on the same and the same	Ell I. Dun and June / a muine mat mains burne and but the Diam Net	4/4/0004	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).		
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		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).		12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999

0625T	Automated quantification and characterization of coronary atherosclerotic plaque	TELL: Procedure/service not reimburged by the Plan Not	1/1/2021	12/31/2999
00231	to assess severity of coronary disease, using data from coronary computed	subject to pre-service review. Check EIU policy, which	1/ 1/2021	12/31/2999
	tomographic angiography; computerized analysis of data from coronary	is one of our Clinical Payment and Coding Policy		
	computed tomographic angiography	(CPCP).		
0626T	Automated quantification and characterization of coronary atherosclerotic plaque	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	to assess severity of coronary disease, using data from coronary computed	subject to pre-service review. Check EIU policy, which		
	tomographic angiography; review of computerized analysis output to reconcile	is one of our Clinical Payment and Coding Policy		
	discordant data, interpretation and report	(CPCP).		
0626T	Automated quantification and characterization of coronary atherosclerotic plaque		1/1/2021	12/31/2999
	to assess severity of coronary disease, using data from coronary computed	subject to pre-service review. Check EIU policy, which		
	tomographic angiography; review of computerized analysis output to reconcile	is one of our Clinical Payment and Coding Policy		
	discordant data, interpretation and report	(CPCP).		
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance,	subject to pre-service review. Check EIU policy, which		
	lumbar; first level	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance,	subject to pre-service review. Check EIU policy, which		
	lumbar; first level	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance,	subject to pre-service review. Check EIU policy, which		
	lumbar; each additional level (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance,	subject to pre-service review. Check EIU policy, which		
	lumbar; each additional level (List separately in addition to code for primary	is one of our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first	subject to pre-service review. Check EIU policy, which		
	level	is one of our Clinical Payment and Coding Policy		
2222		(CPCP).	4/4/0004	10/04/0000
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first	subject to pre-service review. Check EIU policy, which		
	level	is one of our Clinical Payment and Coding Policy		
OCCOT	Percutaneous injection of allogeneic cellular and/or tissue-based product,	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/21/2000
0630T			1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar;	subject to pre-service review. Check EIU policy, which		
	each additional level (List separately in addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
0630T	Dercutopoous injection of allogopois callular and/or tissue based and/or	(CPCP).	1/1/2024	12/31/2999
00301	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar;	subject to pre-service review. Check EIU policy, which		
	each additional level (List separately in addition to code for primary procedure)	is one of our Clinical Payment and Coding Policy		
0624T	Transcutor cous visible light hyperson extral imaging maccours as a first	(CPCP).	1/1/2021	12/21/2000
0631T	Transcutaneous visible light hyperspectral imaging measurement of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation	subject to pre-service review. Check EIU policy, which		
	and report, per extremity	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

0631T	Transcutaneous visible light hyperspectral imaging measurement of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation	subject to pre-service review. Check EIU policy, which		
	and report, per extremity	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0632T	Percutaneous transcatheter ultrasound 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.		
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
2222		(CPCP).	4440004	10/01/0000
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2021	12/31/2999
	flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
22.12		(CPCP).		10/01/000
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than	subject to pre-service review. Check EIU policy, which		
	for screening for peripheral arterial disease, image acquisition, interpretation, and			
00.10	report; first anatomic site	(CPCP).	7/4/0004	40/04/0000
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than	subject to pre-service review. Check EIU policy, which		
	for screening for peripheral arterial disease, image acquisition, interpretation, and			
0040T	report; first anatomic site	(CPCP).	7/4/0004	40/04/0000
0643T	Transcatheter left ventricular restoration device implantation including right and	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	left heart catheterization and left ventriculography when performed, arterial	Medical Policy Criteria. Submit for Recommended		
0645T	approach Transcatheter implantation of coronary sinus reduction device including vascular	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
00431	access and closure, right heart catheterization, venous angiography, coronary	Medical Policy Criteria. Submit for Recommended	77 17202 1	12/3 1/2999
	sinus angiography, imaging guidance, and supervision and interpretation, when	Clinical Review to avoid post-service review.		
	performed	Cililical Review to avoid post-service review.		
0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	valve, percutaneous approach, including right heart catheterization, temporary	Medical Policy Criteria. Submit for Recommended	., ,,	1
	pacemaker insertion, and selective right ventricular or right atrial angiography,	Clinical Review to avoid post-service review.		
	when performed			
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	monitor system, with iterative adjustment of the implantable device to test the	Medical Policy Criteria. Submit for Recommended		
	function of the device and select optimal permanently programmed values with	Clinical Review to avoid post-service review.		
	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. Not	1/1/2023	12/31/2999
	including intraprocedural positioning of capsule, with interpretation and report	subject to pre-service review. Check EIU policy, 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. Not	1/1/2023	12/31/2999
	including intraprocedural positioning of capsule, with interpretation and report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
00001	segments	subject to pre-service review. Check EIU policy, which	17 1/2021	12/01/2000
	Segments	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
	segments	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 vertebral	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
	segments	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00577		(CPCP).	7/4/0004	10/04/0000
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2021	12/31/2999
	segments	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	0/45/2024	12/31/2999
00041	Donor hysterectomy (including cold preservation), open, from cadaver donor	subject to pre-service review. Check EIU policy, which	0/13/2021	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
000+1	Bottor Hydioreolothy (moldaling oold procervation), opon, nom oddavor donor	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0665T	Donor hysterectomy (including cold preservation); open, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0665T	Donor hysterectomy (including cold preservation); open, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		101010000
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	living donor	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/45/2024	12/31/2999
00001		subject to pre-service review. Check EIU policy, which	0/13/2021	12/31/2999
	living donor	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
00071	transplantation from cadaver or living donor	subject to pre-service review. Check EIU policy, which	0, 10,2021	12/01/2000
	anoplanation form oddavor or living donor	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	transplantation from cadaver or living donor	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 allograft prior	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
00001	to transplantation, including dissection and removal of surrounding soft tissues	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
	and preparation of uterine vein(s) and uterine artery(ies), as necessary	is one of our Clinical Payment and Coding Policy		
	and proparation of atomic voin(o) and atomic artery(100), as necessary	(CPCP).		
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	to transplantation, including dissection and removal of surrounding soft tissues	subject to pre-service review. Check EIU policy, which		
	and preparation of uterine vein(s) and uterine artery(ies), as necessary	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	transplantation; venous anastomosis, each	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 to	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	transplantation; venous anastomosis, each	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0070T	Dealth and has a make satisfact of and a san an living a damper stance of the satisfact of	(CPCP).	0/45/0004	40/24/2000
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to	EIU: Procedure/service not reimbursed by the Plan. Not	0/15/2021	12/31/2999
	transplantation; arterial anastomosis, each	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
00701	transplantation; arterial anastomosis, each	subject to pre-service review. Check EIU policy, which	0/13/2021	12/31/2999
	transplantation, arterial anastomosis, caon	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	tissues surrounding the female bladder neck and proximal urethra for urinary	subject to pre-service review. Check EIU policy, which		1-1-1-11-11
	incontinence	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	tissues surrounding the female bladder neck and proximal urethra for urinary	subject to pre-service review. Check EIU policy, which		
	incontinence	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.	4.4.4.4000.4	10/04/0000
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		
0740T	Remote autonomous algorithm-based recommendation system for insulin dose	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
07401	calculation and titration; initial set-up and patient education	Medical Policy Criteria. Submit for Recommended	3/ 1/2023	12/3 1/2999
	ממיסמומנוטוז מווע וווימנוטוז, ווווומו ספניעף מווע ףמנוכות פעעטמנוטוז	Clinical Review to avoid post-service review.		
0741T	Remote autonomous algorithm-based recommendation system for insulin dose	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
[		Medical Policy Criteria. Submit for Recommended	0. 1,2020	12,01,2000
	storage, each 30 days	Clinical Review to avoid post-service review.		
0743T	Bone strength and fracture risk using finite element analysis of functional data	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	and bone mineral density (BMD), with concurrent vertebral fracture assessment,	subject to pre-service review. Check EIU policy, which		
	utilizing data from a computed tomography scan, retrieval and transmission of	is one of our Clinical Payment and Coding Policy		
	the scan data, measurement of bone strength and 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 data	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
07431	and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	17 172023	12/3//2999
	the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	(CPCP).		
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2023	12/31/2999
	imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve		7/1/2023	12/31/2999

0707T		This December 1 and 1 an	7/4/0000	40/04/0000
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0767T	including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772Т	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0773Т	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older		9/1/2023	12/31/2999

0773T	Virtual reality (VR) procedural dissociation services provided by a physician or	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2023	12/31/2999
	other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	subject to pre-service review. Check EIU policy, which		
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)		9/1/2023	12/31/2999
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)		9/1/2023	12/31/2999
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	9/1/2023	12/31/2999
0777Т	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0779Т	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0779Т	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0780T	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2023	12/31/2999
	9.00.0	Clinical Review to avoid post-service review.		
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2023	12/31/2999
	and circumferential radiofrequency destruction of the pulmonary nerves,	subject to pre-service review. Check EIU policy, which		
	including fluoroscopic guidance when performed; bilateral mainstem bronchi	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0781T		EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2023	12/31/2999
	and circumferential radiofrequency destruction of the pulmonary nerves,	subject to pre-service review. Check EIU policy, which		
	including fluoroscopic guidance when performed; bilateral mainstem bronchi	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0782T		EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2023	12/31/2999
	and circumferential radiofrequency destruction of the pulmonary nerves,	subject to pre-service review. Check EIU policy, which		
	including fluoroscopic guidance when performed; unilateral mainstem bronchus	is one of our Clinical Payment and Coding Policy		
0700T	Describes a second district of the second se	(CPCP).	0/4/0000	40/04/0000
0782T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	9/1/2023	12/31/2999
	and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	is one of our Clinical Payment and Coding Policy		
	including hubroscopic guidance when performed, unhateral mainstern pronchus	(CPCP).		
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
07001	education on use of equipment	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
	oddodion on doc or equipment	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	education on use of equipment	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0784T		MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	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 integrated	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	neurostimulator	Medical Policy Criteria. Submit for Recommended		
0700T		Clinical Review to avoid post-service review.	0/45/0004	10/04/0000
0786T		MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	neurostimulator, including imaging guidance, when performed	Medical Policy Criteria. Submit for Recommended		
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
07071		Medical Policy Criteria. Submit for Recommended	0/10/2024	12/3/1/2333
	The account to the ac	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 contact	Medical Policy Criteria. Submit for Recommended		12,5 ., 2555
	group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose	Clinical Review to avoid post-service review.		
	lockout, patient-selectable parameters, responsive neurostimulation, detection			
	algorithms, closed-loop parameters, and passive parameters, when performed			
1	by physician or other qualified health care professional, spinal cord or sacral			
	nerve, 1-3 parameters			

0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0790T	performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0793T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial	Medical Policy Criteria. Submit for Recommended		1.2.0.1.2.00
	angiography, right ventriculography, femoral venography), when performed; right			
	atrial pacemaker component			
T0080	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 atrial	Medical Policy Criteria. Submit for Recommended		
	angiography, right ventriculography, femoral venography), when performed; right	Clinical Review to avoid post-service review.		
	ventricular pacemaker component (when part of a dual-chamber leadless	'		
	pacemaker system)			
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound,	Medical Policy Criteria. Submit for Recommended		
	right atrial angiography, right ventriculography, femoral venography) and device	Clinical Review to avoid post-service review.		
	evaluation (eg, interrogation or programming), when performed; dual-chamber	F		
	system (ie, right atrial and right ventricular pacemaker components)			
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound,	Medical Policy Criteria. Submit for Recommended		
	right atrial angiography, right ventriculography, femoral venography) and device	Clinical Review to avoid post-service review.		
	evaluation (eg, interrogation or programming), when performed; right atrial	F		
	pacemaker component			
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound,	Medical Policy Criteria. Submit for Recommended		
	right atrial angiography, right ventriculography, femoral venography) and device	Clinical Review to avoid post-service review.		
	evaluation (eg, interrogation or programming), when performed; right ventricular	F		
	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
		Medical Policy Criteria. Submit for Recommended		
	programmed values, with analysis, review, and report, by a physician or other	Clinical Review to avoid post-service review.		
	qualified health care professional, leadless pacemaker system in dual cardiac	'		
	chambers			
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	caval valve implantation [CAVI]); percutaneous femoral vein approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	caval valve implantation [CAVI]); open femoral vein approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0807T	Pulmonary tissue ventilation analysis using software-based processing of data	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2023	12/31/2999
	from separately captured cinefluorograph images; in combination with previously	subject to pre-service review. Check EIU policy, which		
	acquired computed tomography (CT) images, including data preparation and	is one of our Clinical Payment and Coding Policy		
	transmission, quantification of pulmonary tissue ventilation, data review,	(CPCP).		
	interpretation and report			
0807T	Pulmonary tissue ventilation analysis using software-based processing of data	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2023	12/31/2999
	from separately captured cinefluorograph images; in combination with previously			
	acquired computed tomography (CT) images, including data preparation and	is one of our Clinical Payment and Coding Policy		
	transmission, quantification of pulmonary tissue ventilation, data review,	(CPCP).		
	interpretation and report	,		

0808T	Pulmonary tissue ventilation analysis using software-based processing of data	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	., .,	12/01/2000
	tomography (CT) images taken for the purpose of pulmonary tissue ventilation	is one of our Clinical Payment and Coding Policy		
	analysis, including data preparation and transmission, quantification of	(CPCP).		
	pulmonary tissue ventilation, data review, interpretation and report	(		
0808T	Pulmonary tissue ventilation analysis using software-based processing of data	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
	tomography (CT) images taken for the purpose of pulmonary tissue ventilation	is one of our Clinical Payment and Coding Policy		
	analysis, including data preparation and transmission, quantification of	(CPCP).		
	pulmonary tissue ventilation, data review, interpretation and report			
)810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	retinotomies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0811T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment);	Non Covered: Procedure/service not covered by the	1/1/2024	12/31/2999
	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 equipment);	Non Covered: Procedure/service not covered by the	1/1/2024	12/31/2999
	device supply with automated report generation, up to 10 days	Plan. Not subject to pre-service review.		
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	intragastric bariatric balloon	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	intragastric bariatric balloon	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of	MP Criteria: Procedure/service reviewed against	4/1/2024	6/30/2024
	intragastric bariatric balloon	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0816T	Open insertion or replacement of integrated neurostimulation system for bladder	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	dysfunction including electrode(s) (eg, array or leadless), and pulse generator or	subject to pre-service review. Check EIU policy, which		
	receiver, including analysis, programming, and imaging guidance, when	is one of our Clinical Payment and Coding Policy		
	performed, posterior tibial nerve; subcutaneous	(CPCP).		
0816T	Open insertion or replacement of integrated neurostimulation system for bladder	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	dysfunction including electrode(s) (eg, array or leadless), and pulse generator or	subject to pre-service review. Check EIU policy, which		
	receiver, including analysis, programming, and imaging guidance, when	is one of our Clinical Payment and Coding Policy		
20407	performed, posterior tibial nerve; subcutaneous	(CPCP).	5/45/0004	0/00/0004
0816T	Open insertion or replacement of integrated neurostimulation system for bladder	MP Criteria: Procedure/service reviewed against	5/15/2024	6/30/2024
	dysfunction including electrode(s) (eg, array or leadless), and pulse generator or	Medical Policy Criteria. Submit for Recommended		
	receiver, including analysis, programming, and imaging guidance, when	Clinical Review to avoid post-service review.		
20.40 <b>T</b>	performed, posterior tibial nerve; subcutaneous		7/4/0004	10/04/0000
0818T	Revision or removal of integrated neurostimulation system for bladder	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	dysfunction, including analysis, programming, and imaging, when performed,	subject to pre-service review. Check EIU policy, which		
	posterior tibial nerve; subcutaneous	is one of our Clinical Payment and Coding Policy		
0040T	Destrict and the second of the	(CPCP).	7/4/0004	40/04/0000
0818T	Revision or removal of integrated neurostimulation system for bladder	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	dysfunction, including analysis, programming, and imaging, when performed,	subject to pre-service review. Check EIU policy, which		
	posterior tibial nerve; subcutaneous	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

0818T	Revision or removal of integrated neurostimulation system for bladder	MP Criteria: Procedure/service reviewed against	5/15/2024	6/30/2024
	dysfunction, including analysis, programming, and imaging, when performed,	Medical Policy Criteria. Submit for Recommended		
	posterior tibial nerve; subcutaneous	Clinical Review to avoid post-service review.		
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial	Medical Policy Criteria. Submit for Recommended		
	angiography and/or right ventriculography, femoral venography, cavography) and	Clinical Review to avoid post-service review.		
	device evaluation (eg, interrogation or programming), when performed	·		
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial			
	angiography and/or right ventriculography, femoral venography, cavography), when performed	Clinical Review to avoid post-service review.		
0825T	Transcatheter removal and replacement of permanent single-chamber leadless	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	pacemaker, right atrial, including imaging guidance (eg. fluoroscopy, venous	Medical Policy Criteria. Submit for Recommended		
1	ultrasound, right atrial angiography and/or right ventriculography, femoral	Clinical Review to avoid post-service review.		
1	venography, cavography) and device evaluation (eg, interrogation or			
	programming), when performed			
0826T	Programming device evaluation (in person) with iterative adjustment of the	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	implantable device to test the function of the device and select optimal	Medical Policy Criteria. Submit for Recommended		
	permanent programmed values with analysis, review and report by a physician or	Clinical Review to avoid post-service review.		
	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. Not	10/1/2024	12/31/2999
	measurement of evoked cortical potentials with automated report	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).	10/1/0001	10/01/0000
0858T	Externally applied transcranial magnetic stimulation with concomitant	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	measurement of evoked cortical potentials with automated report	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
1	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 ventricular	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	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 ventricular	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	pacing, including device interrogation and programming; battery component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	pacing, including device interrogation and programming; transmitter component	Medical Policy Criteria. Submit for Recommended		
0004T	only	Clinical Review to avoid post-service review.	7/4/0004	40/04/0000
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum,	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	low energy	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0064T	Low intensity outreserners all sheet ways thereny involving	(CPCP).	7/1/2024	12/21/2000
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	7/1/2024	12/31/2999
	low energy	is one of our Clinical Payment and Coding Policy		
		,		
		(CPCP).		

0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum,	MP Criteria: Procedure/service reviewed against	4/1/2024	6/30/2024
	low energy	Medical Policy Criteria. Submit for Recommended	., .,_0	0,00,202
	lion onergy	Clinical Review to avoid post-service review.		
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous,	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	including pump-pocket creation, insertion of tunneled indwelling bladder and	Medical Policy Criteria. Submit for Recommended		
	peritoneal catheters with pump connections, including all imaging and initial	Clinical Review to avoid post-service review.		
	programming, when performed	Ciminal Notice to avoid poor control of the control		
0871T		MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	between pump and indwelling bladder and peritoneal catheters, including initial	Medical Policy Criteria. Submit for Recommended		
	programming and imaging, when performed	Clinical Review to avoid post-service review.		
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	including imaging and programming, when performed	Clinical Review to avoid post-service review.		
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	component (ascites pump, associated peritoneal catheter, associated bladder	Medical Policy Criteria. Submit for Recommended		
	catheter), including imaging and programming, when performed	Clinical Review to avoid post-service review.		
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	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 system by	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	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 (family	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	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 other	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	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 or inter	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
	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 Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0210	Non-emergency transportation: ancillary: meals-escort	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)	Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2014	12/31/2999
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0888	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999

A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/15/2022	12/31/2999
712000	Trovosorb sympath definial matrix, per square continued	subject to pre-service review. Check EIU policy, which	12/01/2000
		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. Not 4/15/2022	12/31/2999
		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. Not 4/15/2022	12/31/2999
		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. Not 4/15/2022	12/31/2999
		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. Not 4/15/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
40000	The second secon	(CPCP).	40/04/0000
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/15/2022	12/31/2999
		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. Not 4/15/2022	12/31/2999
A2009	Symphony, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/15/2022	12/31/2999
	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	subject to pre-service review. Check EIU policy, which	12.0 1.200
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/15/2022	12/31/2999
		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. Not 4/15/2022	12/31/2999
		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. Not 8/1/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
A 0044	0	(CPCP).	40/04/0000
A2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/31/2999
		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. Not 8	8/1/2022	12/31/2999
		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. Not 8	8/1/2022	12/31/2999
		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. Not 8	8/1/2022	12/31/2999
		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. Not 8	8/1/2022	12/31/2999
		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. Not 4	4/1/2023	12/31/2999
		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. Not 4	4/1/2023	12/31/2999
		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. Not 4	4/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
10015	But the second	(CPCP)	4/4/0000	10/04/0000
A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4	4/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
A 2016	Dermonderm han equare continueter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 4	4/4/2022	12/31/2999
A2016	Permeaderm b, per square centimeter	subject to pre-service review. Check EIU policy, which	4/ 1/2023	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4	A/1/2023	12/31/2999
72010	r enneadenn b, per square centimeter	subject to pre-service review. Check EIU policy, which	4/1/2023	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not 4	4/1/2023	12/31/2999
011	. Simoddonn gioro, odon	subject to pre-service review. Check EIU policy, which	2020	12,01,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not 4	4/1/2023	12/31/2999
	J 3.5.0, 545	subject to pre-service review. Check EIU policy, which		, 5 ,, _ 5 5 5
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2023	12/31/2999
A2010	l emeadem c, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2393
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		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. Not 9/1/2023	12/31/2999
		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. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
A 2022		(CPCP).	40/24/2000
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 10/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy (CPCP).	
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 10/1/2023	12/31/2999
A2022	Initiovabulti of littlovalitatity xi, per square certificeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 10/1/2023	12/31/2999
A2020	innovalitatity pu, 1 mg	subject to pre-service review. Check EIU policy, which	12/3/1/2333
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 10/1/2023	12/31/2999
A2023	ililiovalilatiix pu, Tilig	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
		I(UFUF).	

A2024	Resolve matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2023	12/31/2999
	, tooshio maan, por oquato osminioo	subject to pre-service review. Check EIU policy, which	10,1,2020	12/3 //2000
		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. Not	10/1/2023	12/31/2999
		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. Not	10/1/2023	12/31/2999
		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. Not	10/1/2023	12/31/2999
		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. Not	4/1/2024	12/31/2999
		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. Not	4/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4244	Alcohol or peroxide, per pint	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A4246	Betadine or phisohex solution, per pint	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A4240	betautile of philsoriex 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
M4241	betautile of fourtie swabs/wipes, per box	Plan. Not subject to pre-service review.	1/1/1950	12/3 1/2999
A4335	Incontinence supply; miscellaneous	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
711000	moonand dappiy, middenanddad	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
, , , , , , , , , , , , , , , , , , , ,	only, each	Medical Policy Criteria. Submit for Recommended	11/10/2020	12/01/2000
	5,, 55	Clinical Review to avoid post-service review.		
A4342	Accessories for patient inserted indwelling intraurethral drainage device with	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	valve, replacement only, each	Medical Policy Criteria. Submit for Recommended		1-73 11-33
	,,,, ,	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.		1.2.3.7.2.3.3
A4495	Surgical stockings thigh length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4500	Surgical stockings below knee length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4510	Surgical stockings full length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	the upper arm	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 nerves of	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	the upper arm	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 nerves of	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	the upper arm	Medical Policy Criteria. Submit for Recommended		
		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		
		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. Not	5/15/2024	12/31/2999
	peripheral nerves of the wrist	subject to pre-service review. Check EIU policy, 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. Not	5/15/2024	12/31/2999
	peripheral nerves of the wrist	subject to pre-service review. Check EIU policy, 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
	peripheral nerves of the wrist	Medical Policy Criteria. Submit for Recommended		
		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
		Plan. Not subject to pre-service review.	0/45/0045	10/01/0000
A4555	Electrode/transducer for use with electrical stimulation device used for cancer	MP Criteria: Procedure/service reviewed against	6/15/2017	12/31/2999
	treatment, replacement only	Medical Policy Criteria. Submit for Recommended		
A 4550	COMPLICATIVE OF LOR PACTE FOR LICE WITH ELECTRICAL REVICE /F.O.	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
A4558		Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A 4500	TENS, NMES), PER OZ	Plan. Not subject to pre-service review.	4/45/0004	40/04/0000
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan. Not	1/15/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
A 4500	November of a triangle of the state of the s	(CPCP).	4/45/2024	12/31/2999
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan. Not	1/15/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	MP Criteria: Procedure/service reviewed against	10/15/2023	1/14/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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, per	EIU: Procedure/service not reimbursed by the Plan. Not	4/1/2023	12/31/2999
	month	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).	4/4/0000	10/01/0000
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories, per	EIU: Procedure/service not reimbursed by the Plan. Not	4/1/2023	12/31/2999
	month	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
A 4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE,	(CPCP).  MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
A4600			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
A4030	Replacement battery for patient-owned ear pulse generator, each	Medical Policy Criteria. Submit for Recommended	3/1/2024	12/31/2999
		Clinical Review to avoid post-service review.		
A4639	Replacement pad for infrared heating pad system, each	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
711000	Tropiacomoni pad for ilmarod floating pad cyclom, cach	subject to pre-service review. Check EIU policy, which	0/1/2020	12/01/2000
		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. Not	9/1/2020	12/31/2999
		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
10000		Plan. Not subject to pre-service review.	0///0000	10/01/0000
A6000	Non-contact wound warming wound cover for use with the non-contact wound	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	warming device and warming card	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
A 6000	Non-contact wound warming wound cover for use with the	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/4/2020	12/31/2999
A6000	Non-contact wound warming wound cover for use with the non-contact wound	subject to pre-service review. Check EIU policy, which	9/1/2020	12/31/2999
	warming device and warming card	is one of our Clinical Payment and Coding Policy		
		•		
		(CPCP).		

A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	adhesive border, each dressing	Plan. Not subject to pre-service review.		
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But less than	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	or equal to 48 sq. In., without adhesive border, each dressing	Plan. Not subject to pre-service review.		
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In., without	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	adhesive border, each dressing	Plan. Not subject to pre-service review.		
A6530	Gradient compression stocking, below knee, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
A6531	Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	dressing, each	Plan. Not subject to pre-service review.		
A6533	Gradient compression stocking, thigh length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
A6534	Gradient compression stocking, thigh 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.		
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
		Plan. Not subject to pre-service review.		
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
		Plan. Not subject to pre-service review.		
A6539	Gradient compression stocking, waist length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
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. Not	9/1/2023	12/31/2999
		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. Not	9/1/2023	12/31/2999
		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, NOT	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
A3203	inversion/eversion correction device	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of		8/1/2022	1/31/2024
7,0201	treatment	subject to pre-service review. Check EIU policy, which	0/1/2022	170172024
	ucamon	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of		8/1/2022	1/31/2024
710201	treatment	subject to pre-service review. Check EIU policy, which	0/1/2022	170172024
	a camon	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of		2/1/2024	12/31/2999
. 1020 1	treatment	Medical Policy Criteria. Submit for Recommended	_, .,	1.2,0 1,2000
		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 AND	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	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 AND	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	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
		Plan. Not subject to pre-service review.		
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	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			
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	fats, carbohydrates, vitamins and minerals, may include fiber, administered	Plan. Not subject to pre-service review.		
	through an enteral feeding tube, 100 calories = 1 unit			
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins	Plan. Not subject to pre-service review.		
	and minerals, may include fiber, administered through an enteral feeding tube,			
D4454	100 calories = 1 unit		4/4/0040	10/04/0000
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes	Non Covered: Procedure/service not covered by the	1/1/2013	12/31/2999
	inherited disease of metabolism, includes altered composition of proteins, fats,	Plan. Not subject to pre-service review.		
	carbohydrates, vitamins and/or minerals, may include fiber, administered through			
B4158	an enteral feeding tube, 100 calories = 1 unit ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
D+100	INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES,	Plan. Not subject to pre-service review.	1/1/2005	12/3/1/2999
	VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON,	Plan. Not subject to pre-service review.		
	ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES =			
	1 UNIT			
	[ I UNIT			

B4159	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
C1761	Catheter, transluminal intravascular lithotripsy, coronary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
C1764	Event recorder, cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
C1778	Lead, neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1817	Septal defect imp sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2014	12/31/2999
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999

C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
C1824	Generator, cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
C1832	Autograft suspension, including cell processing and application, and all system components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
C1832	Autograft suspension, including cell processing and application, and all system components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
C1832	Autograft suspension, including cell processing and application, and all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	5/14/2024
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2016	12/31/2999

C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/16/2019	12/31/2999
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	3/31/2024
C9161	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	3/31/2024
C9168	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	6/30/2024
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per square	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
09004	centimeter	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
	Centimeter	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	(TenoGlide Tendon Protector Sheet), per square centimeter	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 matrix	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	(TenoGlide Tendon Protector Sheet), per square centimeter	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend		12/1/2020	12/31/2999
	Collagen Matrix), per 0.5 square centimeters	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend		12/1/2020	12/31/2999
	Collagen Matrix), per 0.5 square centimeters	subject to pre-service review. Check EIU policy, 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. Not	12/1/2020	12/31/2999
	(SurgiMend Collagen Matrix), per 0.5 square centimeters	subject to pre-service review. Check EIU policy, 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. Not	12/1/2020	12/31/2999
	(SurgiMend Collagen Matrix), per 0.5 square centimeters	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00000		(CPCP).	5/45/0004	10/04/0000
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00000	Oldin and afficial to be a second of the sec	(CPCP).	E/4E/0004	40/04/0000
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
09304	oronie impiant, Ferniaco, per square centinietei	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
23001	1 5.5.110 Implant, 1 ormacol, por oquare continueter	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
	leiomyomata, with magnetic resonance (MR) guidance	Medical Policy Criteria. Submit for Recommended	.5, 15,2014	12/01/2000
	Total and the state of the stat	Clinical Review to avoid post-service review.		
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
	by State Sta	Medical Policy Criteria. Submit for Recommended	1.2, 1/2010	12,01,2000
		Clinical Review to avoid post-service review.		
L	1	Tommodi Atoviow to dvoid post-solvide leview.	I.	

C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9765	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9768	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
C9768	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
C9769	Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2020	12/31/2999
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
30	artery(ies); with intravascular lithotripsy, and transluminal stent placement(s),	subject to pre-service review. Check EIU policy, which	0, 10, 2021	12/01/2000
	includes angioplasty within the same vessel(s), when performed	is one of our Clinical Payment and Coding Policy		
	inclusion angiophany maini and came record(e), milen penemica	(CPCP).		
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty	subject to pre-service review. Check EIU policy, which		
	within the same vessel (s), when performed	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty	subject to pre-service review. Check EIU policy, which		
	within the same vessel (s), when performed	is one of our Clinical Payment and Coding Policy		
		(CPCP).	011510001	10/04/0000
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan. Not	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and			
	atherectomy, includes angioplasty within the same vessel (s), when performed	is one of our Clinical Payment and Coding Policy		
00775	Developed in the condense of t	(CPCP).	0/45/0004	40/24/2000
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	0/13/2021	12/31/2999
	atherectomy, includes angioplasty within the same vessel (s), when performed	is one of our Clinical Payment and Coding Policy		
	atherectomy, includes angiopiasty within the same vesser (s), when performed	(CPCP).		
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes		8/15/2021	12/31/2999
03/11	esophagoscopy or esophagogastroduodenoscopy	subject to pre-service review. Check EIU policy, which	0/13/2021	12/01/2000
	Cooping Good of Cooping Ogustiou du Culticoopy	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes		8/15/2021	12/31/2999
	esophagoscopy or esophagogastroduodenoscopy	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9782	Blinded procedure for new york heart association (nyha) class ii or iii heart	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
	failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory	Medical Policy Criteria. Submit for Recommended		
	angina; transcatheter intramyocardial transplantation of autologous bone marrow	Clinical Review to avoid post-service review.		
	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			
00704	approved investigational device exemption (ide) study	THE Day of the Art of the New York and the Art of the Disconnection of the Disconnection of the Art of the Disconnection of the Disconn	40/4/0000	40/04/0000
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2023	12/31/2999
	esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy		
	including all system and tissue anchoring components	(CPCP).		
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2023	12/31/2999
00704	esophagogastroduodenoscopy and intraluminal tube insertion, if performed,	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	including all system and tissue anchoring components	is one of our Clinical Payment and Coding Policy		
	moraling an system and assue anonoming components	(CPCP).		
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2023	12/31/2999
	intraluminal tube insertion, if performed, including all system and tissue	subject to pre-service review. Check EIU policy, which		_,_,
	anchoring components	is one of our Clinical Payment and Coding Policy		

C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2023	12/31/2999
	intraluminal tube insertion, if performed, including all system and tissue	subject to pre-service review. Check EIU policy, which		
	anchoring components	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
C9786	Echocardiography image post processing for computer aided detection of heart	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
	failure with preserved ejection fraction, including interpretation and report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
	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 anorectal	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	fistula) with plug (e.g., porcine small intestine submucosa [sis])	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 anorectal	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	fistula) with plug (e.g., porcine small intestine submucosa [sis])	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 anorectal	MP Criteria: Procedure/service reviewed against	4/1/2024	6/30/2024
	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 tooth,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	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 heavy	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	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, INCLUDES	Non Covered: Procedure/service not covered by the	2/1/2010	12/31/2999
	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
E0221	Infrared heating pad system	Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	9/1/2020	12/31/2999
E0221	Infrared heating pad system	(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).	9/1/2020	12/31/2999
E0231	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0231	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0232	Warming card for use with the non contact wound warming device and non contact wound warming wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0232	Warming card for use with the non contact wound warming device and non contact wound warming wound cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
E0236	Pump for water circulating pad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0240	Bath/shower chair, with or without wheels, any size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0241	Bath tub wall rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0242	Bath tub rail, floor base	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0247	Transfer bench for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0249	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2006	12/31/2999
E0273	Bed board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

E0274	Over-bed table	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
<b>-</b>		Plan. Not subject to pre-service review.	10/1/0000	10/01/0000
E0280	Bed cradle, any type	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.	=/4=/00/4	10/01/0000
E0291	Hospital bed, fixed height, without side rails, without mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		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
		Plan. Not subject to pre-service review.		
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
		Plan. Not subject to pre-service review.		
E0462	Rocking bed with or without side rails	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY	MP Criteria: Procedure/service reviewed against	1/1/2006	7/31/2024
	COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED,	Medical Policy Criteria. Submit for Recommended		
	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. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, 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. Not	9/1/2020	12/31/2999
20101	or momentally, electricatio, involoped rice ricolescondes	subject to pre-service review. Check EIU policy, which	10/1/2020	12/01/2000
		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. Not	10/1/2023	12/31/2999
20100	neuromuscular electrical stimulation of the tongue muscle, controlled by	subject to pre-service review. Check EIU policy, which	10/1/2020	12/01/2000
	hardware remote	is one of our Clinical Payment and Coding Policy		
	nardware remote	(CPCP).		
E0490	Power source and control electronics unit for oral device/appliance for	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2022	12/31/2999
L0490	neuromuscular electrical stimulation of the tongue muscle, controlled by	subject to pre-service review. Check EIU policy, which	10/1/2023	12/31/2999
	hardware remote	is one of our Clinical Payment and Coding Policy		
	nardware remote	(CPCP).		
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2022	12/31/2999
E0491			10/1/2023	12/31/2999
	muscle, used in conjunction with the power source and control electronics unit,	subject to pre-service review. Check EIU policy, which		
	controlled by hardware remote, 90-day supply	is one of our Clinical Payment and Coding Policy		
E0404		(CPCP).	40/4/0000	40/04/0000
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2023	12/31/2999
	muscle, used in conjunction with the power source and control electronics unit,	subject to pre-service review. Check EIU policy, which		
	controlled by hardware remote, 90-day supply	is one of our Clinical Payment and Coding Policy		
==		(CPCP).	0111005	10/01/0005
E0492	Power source and control electronics unit for oral device/appliance for	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
1	neuromuscular electrical stimulation of the tongue muscle, controlled by phone	Medical Policy Criteria. Submit for Recommended		
	application	Clinical Review to avoid post-service review.		
E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	muscle, used in conjunction with the power source and control electronics unit,	Medical Policy Criteria. Submit for Recommended		
	controlled by phone application, 90-day supply	Clinical Review to avoid post-service review.		

E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	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 programmer	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.		
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		
		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
		Plan. Not subject to pre-service review.		
E0650	Pneumatic compressor, non-segmental home model	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0651	Pneumatic compressor, segmental home model without calibrated gradient	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	pressure	Medical Policy Criteria. Submit for Recommended		
		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
	pressure	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half	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.		
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		
		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, full leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	2 full legs and trunk	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		1

E0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	gg	Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		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		
		Clinical Review to avoid post-service review.		
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	arterial insufficiency (unilateral or bilateral system)	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 cycle, for	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	arterial insufficiency (unilateral or bilateral system)	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	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.		
E0681	Non-pneumatic compression controller without calibrated gradient pressure	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.		
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 OR	Medical Policy Criteria. Submit for Recommended		
	LESS	Clinical Review to avoid post-service review.		
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	protection, 4 foot panel	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	protection, 6 foot panel	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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 Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0732	Cranial electrotherapy stimulation (ces) system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0736	Transcutaneous tibial nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
E0740	Non-implanted pelvic floor electrical stimulator, complete system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
E0740	Non-implanted pelvic floor electrical stimulator, complete system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

E0755	Electronic salivary reflex stimulator (intra-oral/non-invasive)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		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		12/15/2014	12/31/2999
E0769	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).		12/31/2999
E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
L0040	Traction frame, attached to fleadboard, cervical traction	subject to pre-service review. Check EIU policy, which	3/1/2020	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME,	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
E0055		(CPCP).	40/45/0044	10/04/0000
E0855	Cervical traction equipment not requiring additional stand or frame	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
E0055		(CPCP).	40/45/0044	40/04/0000
E0855	Cervical traction equipment not requiring additional stand or frame	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	12/15/2014	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E0856	Cervical traction device, with inflatable air bladder(s)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
20000	or roal dation dovice, with initiation an oracle (e)	subject to pre-service review. Check EIU policy, which	0/ 1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E0856	Cervical traction device, with inflatable air bladder(s)	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
	,	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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
20000	Tradion name, addened to restaura, perne datation	subject to pre-service review. Check EIU policy, which	07 172020	12/01/2000
		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 OTHER	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	THAN KNEE	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 OTHER	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	THAN KNEE	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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		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 poster)	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.		
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 fixed	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	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 mounting	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	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 mounting	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 wheelchair to	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 wheelchair to	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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 DRIVE,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	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 mechanical	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	shear reduction	Medical Policy Criteria. Submit for Recommended	1	
	5.154. 154451311	Clinical Review to avoid post-service review.		
E1005	Wheelchair accessory, power seating system, recline only, with power shear	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	reduction	Medical Policy Criteria. Submit for Recommended	0.220 .2	12,0 ., 2000
	Toddostori	Clinical Review to avoid post-service review.	1	
<u> </u>	<u> </u>	Tominoa Neview to avoid post-service review.	1	1

E1006	Wheelchair accessory, power seating system, combination tilt and recline,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
İ	without shear reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1007	Wheelchair accessory, power seating system, combination tilt and recline, 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.		
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	power shear reduction	Medical Policy Criteria. Submit for Recommended		
	ľ	Clinical Review to avoid post-service review.		
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg		6/1/2006	12/31/2999
	elevation system, including pushrod and leg rest, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1010	Wheelchair accessory, addition to power seating system, power leg elevation	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	system, including leg rest, pair	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1012	Wheelchair accessory, addition to power seating system, center mount power	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	elevating leg rest/platform, complete system, any type, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	hardware for joystick, other control interface or positioning accessory	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1083	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg res		3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	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.		
E1087	High strength lightweight wheelchair, fixed full length arms, swing away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	detachable elevating leg rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1170	Amputee wheelchair, fixed full length arms, swing away detachable elevating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1171	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		
		Clinical Review to avoid post-service review.		
E1172	Amputee wheelchair, detachable arms (desk or full length) without footrests or	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	legrest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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 elevating	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1200	Amputee wheelchair, fixed full length arms, swing away detachable footrest	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.		

E1220	Wheelchair; specially sized or constructed, (indicate brand name, model number,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	if any) and justification	Medical Policy Criteria. Submit for Recommended		1
		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 15	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	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 80	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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		
		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
		Medical Policy Criteria. Submit for Recommended		
		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		
		Clinical Review to avoid post-service review.		
E1230	Power operated vehicle (three or four wheel nonhighway) specify brand name	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and model number	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating 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.		
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	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.		
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	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.		
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	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.		
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.		
E1301	Whirlpool tub, walk-in, portable	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.		
E1310	Whirlpool, non-portable (built-in type)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1355	Stand/rack	Non Covered: Procedure/service not covered by the	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		
		Clinical Review to avoid post-service review.		

E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
L 1002	Wediable artificial Nuffey, each	subject to pre-service review. Check EIU policy, which	1/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
	<b>,</b>	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. Of 200	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	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.		
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than or	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 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.		
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22	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.		
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 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.		
E2206	Manual wheelchair accessory, wheel lock assembly, complete, replacement only,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	each	Medical Policy Criteria. Submit for Recommended		
		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
		Plan. Not subject to pre-service review.		
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		
		Clinical Review to avoid post-service review.		
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC 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.		
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		
	μ	Clinical Review to avoid post-service review.		
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC 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.		

E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended	., .,	12.5
	, , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	ANY SIZE. EACH	Medical Policy Criteria. Submit for Recommended		
	7.11.1 5.22, 2.151.	Clinical Review to avoid post-service review.		
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED 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.		
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION 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.		
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	replacement only, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	size, replacement only, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	wheel, any size, replacement only, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	LOCK, COMPLETE, EACH	Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	(REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware	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.		
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	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.		
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	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.		
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	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.		
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR,	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF	Medical Policy Criteria. Submit for Recommended		
	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 electronics,	Medical Policy Criteria. Submit for Recommended		
	indicator feature, mechanical function selection switch, and fixed mounting hardware	Clinical Review to avoid post-service review.		
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 related	Medical Policy Criteria. Submit for Recommended	0, 10,200.	1.2/6 // 2000
l	electronics, indicator feature, mechanical function selection switch, and fixed	Clinical Review to avoid post-service review.		
	mounting hardware	Cimiladi Navian ta dvald paat aalvida lavian.		
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		
	, and the second	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, and	Medical Policy Criteria. Submit for Recommended		
	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 stop	Medical Policy Criteria. Submit for Recommended		
	switch, and fixed mounting hardware	Clinical Review to avoid post-service review.		
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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, including all	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	related electronics, mechanical stop switch, and manual swingaway mounting	Medical Policy Criteria. Submit for Recommended		
	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, proportional,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	including all related electronics, mechanical direction change switch, and fixed	Medical Policy Criteria. Submit for Recommended		
	mounting hardware	Clinical Review to avoid post-service review.		
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 mounting	Medical Policy Criteria. Submit for Recommended		
	hardware	Clinical Review to avoid post-service review.		
E2329	Power wheelchair accessory, head control interface, contact switch mechanism,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	nonproportional, including all related electronics, mechanical stop switch,	Medical Policy Criteria. Submit for Recommended		
	mechanical direction change switch, head array, and fixed mounting hardware	Clinical Review to avoid post-service review.		

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

E2367	Power wheelchair accessory, battery charger, dual mode, for use with either	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 ACID	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 remote	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	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 CONTROLLER,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE,	Medical Policy Criteria. Submit for Recommended		
	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 HARDWARE,	Medical Policy Criteria. Submit for Recommended		
	REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE,	Medical Policy Criteria. Submit for Recommended		
	UPGRADE PROVIDED AT INITIAL ISSUE	Clinical Review to avoid post-service review.		
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2500	Speech generating device, digitized speech, using pre-recorded messages, less	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	than or equal to 8 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2502	Speech generating device, digitized speech, using pre-recorded messages,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	greater than 8 minutes but less than or equal to 20 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2504	Speech generating device, digitized speech, using pre-recorded messages,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	greater than 20 minutes but less than or equal to 40 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2506	Speech generating device, digitized speech, using pre-recorded messages,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	greater than 40 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2508	Speech generating device, synthesized speech, requiring message formulation	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	by spelling and access by physical contact with the device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2510	Speech generating device, synthesized speech, permitting multiple methods of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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 digital	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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
		Medical Policy Criteria. Submit for Recommended		
		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		
		Clinical Review to avoid post-service review.		
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		1-7-77-10-1
		Clinical Review to avoid post-service review.		
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
	, '	Clinical Review to avoid post-service review.		
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	WIDTH LESS THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
	·	Clinical Review to avoid post-service review.		
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	WIDTH 22 INCHES OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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		
		Clinical Review to avoid post-service review.		
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING	Medical Policy Criteria. Submit for Recommended		
	HARDWARE	Clinical Review to avoid post-service review.		
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING	Medical Policy Criteria. Submit for Recommended	1	
	HARDWARE	Clinical Review to avoid post-service review.		
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE	Medical Policy Criteria. Submit for Recommended		
	MOUNTING HARDWARE	Clinical Review to avoid post-service review.		

E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL,	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE	Medical Policy Criteria. Submit for Recommended		
	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
	INCLUDING ANY TYPE MOUNTING HARDWARE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT,	Medical Policy Criteria. Submit for Recommended		
	INCLUDING ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
E2621	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 HEIGHT,	Medical Policy Criteria. Submit for Recommended		
	INCLUDING ANY TYPE MOUNTING HARDWARE	Clinical Review to avoid post-service review.		
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	LESS THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
İ	22 INCHES OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	Medical Policy Criteria. Submit for Recommended		
	, , , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT	Medical Policy Criteria. Submit for Recommended		
	(FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	Clinical Review to avoid post-service review.		
E2630		MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW	Medical Policy Criteria. Submit for Recommended		
	FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	Clinical Review to avoid post-service review.		
E2631	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT,	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 CONTROL	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
•	SUPINATOR	Medical Policy Criteria. Submit for Recommended		
i		Clinical Review to avoid post-service review.		

E3000	Speech volume modulation system, any type, including all components and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	accessories	subject to pre-service review. Check EIU policy, which		1.2.0.0.2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
E3000	Speech volume modulation system, any type, including all components and	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2024	12/31/2999
	accessories	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 and	MP Criteria: Procedure/service reviewed against	2/15/2024	5/14/2024
	accessories	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 recreation,	MP Criteria: Procedure/service reviewed against	7/15/2006	12/31/2999
	related to the care and treatment of patient's disabling mental health problems,	Medical Policy Criteria. Submit for Recommended		
	per session (45 minutes or more)	Clinical Review to avoid post-service review.		
G0255	Current perception threshold/sensory nerve conduction test, (snct) per limb, any	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	nerve	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 limb, any	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	nerve	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 lumbar	Non Covered: Procedure/service not covered by the	1/1/2015	12/31/2999
	decompression (pild) or placebo-control, performed in an approved coverage	Plan. Not subject to pre-service review.		
	with evidence development (ced) clinical trial			
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis	subject to pre-service review. Check EIU policy, which		
	ulcers not demonstrating measurable signs of healing after 30 days of	is one of our Clinical Payment and Coding Policy		
	conventional care, as part of a therapy plan of care	(CPCP).		
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis	subject to pre-service review. Check EIU policy, which		
	ulcers not demonstrating measurable signs of healing after 30 days of	is one of our Clinical Payment and Coding Policy		
	conventional care, as part of a therapy plan of care	(CPCP).		
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	than described in g0281	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 other	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	than described in g0281	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
G0293		Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	spinal anesthesia in a medicare qualifying clinical trial, per day	Plan. Not subject to pre-service review.		
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	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		12/15/2014	12/31/2999
	described in g0329 or for other uses	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. Not	12/15/2014	12/31/2999
G0295	described in g0329 or for other uses	subject to pre-service review. Check EIU policy, which	12/13/2014	12/3 1/2999
	described in g0329 or for other uses			
		is one of our Clinical Payment and Coding Policy (CPCP).		
G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not	subject to pre-service review. Check EIU policy, which		
	demonstrating measurable signs of healing after 30 days of conventional care as	is one of our Clinical Payment and Coding Policy		
	part of a therapy plan of care	(CPCP).		
G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv	EIU: Procedure/service not reimbursed by the Plan. Not	12/15/2014	12/31/2999
	pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not	subject to pre-service review. Check EIU policy, which		
	demonstrating measurable signs of healing after 30 days of conventional care as			
	part of a therapy plan of care	(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 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.		
G0343	Laparotomy for 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.		
G0416	Surgical pathology, gross and microscopic examinations, for prostate needle	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
	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., CMI,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	collagen scaffold, Menaflex)	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
C0400	Callanan Mania ava luuniant muaaadiyya fan filling maania aal dafaata (a.g. CMI	(CPCP).	40/4/0000	40/04/0000
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI,	,	12/1/2020	12/31/2999
	collagen scaffold, Menaflex)	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 syndrome (LDS)		9/24/2012	12/31/2999
00429	(e.g., as a result of highly active antiretroviral therapy.)	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/3 1/2999
	(e.g., as a result of highly active antiferrovital therapy.)	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
00400	assessment of donor specimen	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/3 1/2333
	docosiment of donor opposition	Clinical Review to avoid post-service review.		
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or	subject to pre-service review. Check EIU policy, which		,
	mixing, and all other preparatory procedures, administration and dressings, per	is one of our Clinical Payment and Coding Policy		
	treatment	(CPCP).		
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or	subject to pre-service review. Check EIU policy, which		
	mixing, and all other preparatory procedures, administration and dressings, per	is one of our Clinical Payment and Coding Policy		
	treatment	(CPCP).		
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic	EIU: Procedure/service not reimbursed by the Plan. Not	4/1/2022	12/31/2999
	chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes			
	as applicable administration, dressings, phlebotomy, centrifugation or mixing,	is one of our Clinical Payment and Coding Policy		
	and all other preparatory procedures, per treatment)	(CPCP).		

G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic	EIU: Procedure/service not reimbursed by the Plan. Not	4/1/2022	12/31/2999
	chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes			
	as applicable administration, dressings, phlebotomy, centrifugation or mixing,	is one of our Clinical Payment and Coding Policy		
	and all other preparatory procedures, per treatment)	(CPCP).		
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services for	MP Criteria: Procedure/service reviewed against	1/1/2018	9/14/2024
	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 more	MP Criteria: Procedure/service reviewed against	1/1/2018	9/14/2024
	(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 qualified	Medical Policy Criteria. Submit for Recommended		
	health care professional and provision of up to 56 mg of esketamine nasal self-	Clinical Review to avoid post-service review.		
	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
İ	established patient that requires the supervision of a physician or other qualified	Medical Policy Criteria. Submit for Recommended		
	health care professional and provision of greater than 56 mg esketamine nasal	Clinical Review to avoid post-service review.		
	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 PERFORMED OR	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	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 absorptiometry	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	(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 documented, no	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	reason given	Plan. Not subject to pre-service review.		
G8420	Bmi is documented within normal parameters and no follow-up plan is required	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	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 obtained,	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	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 reviewed by		1/1/2008	12/31/2999
00400	the eligible clinician, reason not given	Plan. Not subject to pre-service review.	4/4/0000	10/04/0000
G8430	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8432	Depression screening not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8433	Screening for depression not completed, documented patient or medical reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8451	Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8452	Beta-blocker therapy not prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8474	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8478	Blood pressure measurement not performed or documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8482	INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY RECEIVED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8483	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8484	Influenza immunization was not administered, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999

G8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM THE	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00002	EAR WITHIN THE PREVIOUS 90 DAYS	Plan. Not subject to pre-service review.	., .,	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
	disorders of the ear) for an otologic evaluation, reason not given	Plan. Not subject to pre-service review.		1.2.5.7.2.5.5
G8564	PATIENT WAS 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, REASON NOT SPECIFIED)	, '		
G8565	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	PROGRESSIVE HEARING LOSS	Plan. Not subject to pre-service review.		
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 LOSS	Plan. Not subject to pre-service review.		
	MEASURE			
G8567	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	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 training in	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	disorders of the ear) for an otologic evaluation, reason not given	Plan. Not subject to pre-service review.		
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 DIALYSIS	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		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 tamponade,	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	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.		
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
		Plan. Not subject to pre-service review.		
G8600	Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	known well	Plan. Not subject to pre-service review.		
G8601	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	known well for reasons documented by clinician (e.g. patient enrolled in clinical	Plan. Not subject to pre-service review.		
	trial for stroke, patient admitted for elective carotid intervention)			
G8602	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last		1/1/2010	12/31/2999
00050	known well, reason not given	Plan. Not subject to pre-service review.	4/4/0000	10/04/0000
G9050	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	cancer diagnosis or recurrence (for use in a medicare-approved demonstration	Plan. Not subject to pre-service review.		
00054	project)	Non-Ordered Broom to the formation and the state of	4/4/0000	40/04/0000
G9051	Oncology; primary focus of visit; treatment decision-making after disease is	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	staged or restaged, discussion of treatment options, supervising/coordinating	Plan. Not subject to pre-service review.		
	active cancer directed therapy or managing consequences of cancer directed			
00050	therapy (for use in a medicare-approved demonstration project)	Non Course de Dress de mala mala maior de la contraction de la con	4/4/0000	40/04/0000
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for patient	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	who has completed definitive cancer-directed therapy and currently lacks	Plan. Not subject to pre-service review.		
	evidence of recurrent disease; cancer directed therapy might be considered in			
	the future (for use in a medicare-approved demonstration project)			

G9053	Oncology; primary focus of visit; expectant management of patient with evidence	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	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)			
G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00001	patient with terminal cancer or for whom other medical illness prevents further	Plan. Not subject to pre-service review.	17 172000	12/01/2000
	cancer treatment; includes symptom management, end-of-life care planning,	Trian. Not subject to pre-service review.		
	management of palliative therapies (for use in a medicare-approved			
	demonstration project)			
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise listed	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
03000	(for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.	17 172000	12/01/2000
G9056	Oncology; practice guidelines; management adheres to guidelines (for use in a	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9030	medicare-approved demonstration project)	•	1/1/2000	12/3 1/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a result of	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9057			1/1/2006	12/31/2999
	patient enrollment in an institutional review board approved clinical trial (for use	Plan. Not subject to pre-service review.		
00050	in a medicare-approved demonstration project)		4/4/0000	10/04/0000
G9058	Oncology; practice guidelines; management differs from guidelines because the	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	treating physician disagrees with guideline recommendations (for use in a	Plan. Not subject to pre-service review.		
	medicare-approved demonstration project)			
G9059	Oncology; practice guidelines; management differs from guidelines because the	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	patient, after being offered treatment consistent with guidelines, has opted for	Plan. Not subject to pre-service review.		
	alternative treatment or management, including no treatment (for use in a			
	medicare-approved demonstration project)			
G9060	Oncology; practice guidelines; management differs from guidelines for reason(s)	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	associated with patient comorbid illness or performance status not factored into	Plan. Not subject to pre-service review.		
	guidelines (for use in a medicare-approved demonstration project)			
G9061	Oncology; practice guidelines; patient's condition not addressed by available	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	guidelines (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9062	Oncology; practice guidelines; management differs from guidelines for other	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	reason(s) not listed (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9063	Oncology; disease status; limited to non-small cell lung cancer; extent of disease	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	initially established as stage i (prior to neo-adjuvant therapy, if any) with no	Plan. Not subject to pre-service review.		
	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 disease	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	initially established as stage ii (prior to neo-adjuvant therapy, if any) with no	Plan. Not subject to pre-service review.		
	evidence of disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9065	Oncology; disease status; limited to non-small cell lung cancer; extent of disease	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
00000	initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no	Plan. Not subject to pre-service review.	17 172000	12/01/2000
	evidence of disease progression, recurrence, or metastases (for use in a	Trian. Not subject to pre-service review.		
	medicare-approved demonstration project)			
G9066	Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
20000	diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-	Plan. Not subject to pre-service review.	1/1/2000	12/01/2000
	approved demonstration project)	Fran. Not subject to pre-service review.		
G9067	Oncology; disease status; limited to non-small cell lung cancer; extent of disease	Non Covered: Precedure/convice not covered by the	1/1/2006	12/31/2999
G9001		•	1/1/2006	12/31/2999
	unknown, staging in progress, or not listed (for use in a medicare-approved	Plan. Not subject to pre-service review.		
	demonstration project)			

G9068	Oncology; disease status; limited to small cell and combined small cell/non-small	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9000	The state of the s	· · · · · · · · · · · · · · · · · · ·	1/ 1/2000	12/31/2999
	cell; extent of disease initially established as limited with no evidence of disease	Plan. Not subject to pre-service review.		
	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
	combined small cell/non-small cell; extensive stage at diagnosis, metastatic,	Plan. Not subject to pre-service review.		
	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 progress,	Plan. Not subject to pre-service review.		
	or not listed (for use in a medicare-approved demonstration project)			
G9071	Oncology; disease status; invasive female breast cancer (does not include ductal	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-	Plan. Not subject to pre-service review.		
	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 include ductal	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage	Plan. Not subject to pre-service review.		
	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 include ductal	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and	Plan. Not subject to pre-service review.		
	not t3, n1, m0; and er and/or pr positive; with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9074	Oncology; disease status; invasive female breast cancer (does not include ductal	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and	Plan. Not subject to pre-service review.		
	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 include ductal	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis,	Plan. Not subject to pre-service review.		
	metastatic, locally recurrent, or progressive (for use in a medicare-approved			
	demonstration project)			
G9077	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; t1-t2c and gleason 2-7 and psa < or equal to 20 at	Plan. Not subject to pre-service review.		
	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	Plan. Not subject to pre-service review.		
	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 evidence of	Plan. Not subject to pre-service review.		
	disease progression, recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9080	Oncology; disease status; prostate cancer, limited to adenocarcinoma; after	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	initial treatment with rising psa or failure of psa decline (for use in a medicare-	Plan. Not subject to pre-service review.		
	approved demonstration project)			

G9083	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9003	disease unknown, staging in progress, or not listed (for use in a medicare-	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	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
03004	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	as t1-3, n0, m0 with no evidence of disease progression, recurrence, or	Plan. Not subject to pre-service review.		
	metastases (for use in a medicare-approved demonstration project)			
G9085	Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9065	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	as t4, n0, m0 with no evidence of disease progression, recurrence, or	Plan. Not subject to pre-service review.		
	metastases (for use in a medicare-approved demonstration project)			
G9086	Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9000	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or	Plan. Not subject to pre-service review.		
	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
G9007	adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2999
	recurrent, or progressive with current clinical, radiologic, or biochemical evidence			
	of disease (for use in a medicare-approved demonstration project)			
G9088	Oncology; disease status; colon cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9000	adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally	Plan. Not subject to pre-service review.	1/ 1/2000	12/31/2999
	recurrent, or progressive without current clinical, radiologic, or biochemical	I fair. Not subject to pre-service review.		
	evidence of disease (for use in a medicare-approved demonstration project)			
G9089	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 unknown, staging in		17 172000	12/01/2000
	progress, or not listed (for use in a medicare-approved demonstration project)	Train. Not subject to pro service review.		
	progress, or not noted for use in a medicare approved demonstration project;			
G9090	Oncology; disease status; rectal 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 established	Plan. Not subject to pre-service review.		
	as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9091	Oncology; disease status; rectal cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.		
	as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease			
	progression, recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9092	Oncology; disease status; rectal cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.		
	as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of			
	disease progression, recurrence or metastases (for use in a medicare-approved			
	demonstration project)			
G9093	Oncology; disease status; rectal cancer, limited to invasive cancer,	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; extent of disease initially established	Plan. Not subject to pre-service review.		
	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)			

			Ī	
G9094	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9095	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9099	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9100	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9101	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9102	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9103	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9104	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9105	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

G9106	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	or r2 resection with no evidence of disease progression, or metastases (for use	Plan. Not subject to pre-service review.		
G9107	in a medicare-approved demonstration project)	Nan Cavanadi Dua aadi wa/aamiisa wat aayanad by tha	1/1/2006	40/04/0000
G9107	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or	Plan. Not subject to pre-service review.		
G9108	progressive (for use in a medicare-approved demonstration project)	Non Covered Dragadure/comics not covered by the	1/1/2006	12/31/2999
G9108	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	of disease unknown, staging in progress, or not listed (for use in a medicare-	Plan. Not subject to pre-service review.		
00400	approved demonstration project)	New Course de Bresse de marte a militar est a course de la collection	4/4/0000	40/04/0000
G9109	Oncology; disease status; head and neck cancer, limited to cancers of oral	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	cavity, pharynx and larynx with squamous cell as predominant cell type; extent of	Plan. Not subject to pre-service review.		
	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 oral	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	cavity, pharynx and larynx with squamous cell as predominant cell type; extent of	Plan. Not subject to pre-service review.		
	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 oral	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at	Plan. Not subject to pre-service review.		
	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 oral	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	cavity, pharynx and larynx with squamous cell as predominant cell type; extent of	Plan. Not subject to pre-service review.		
	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; pathologic	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	stage ia-b (grade 1) without evidence of disease progression, recurrence, or	Plan. Not subject to pre-service review.		
	metastases (for use in a medicare-approved demonstration project)			
G9114	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of	Plan. Not subject to pre-service review.		
	disease progression, recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9115	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	stage iii-iv; without evidence of progression, recurrence, or metastases (for use	Plan. Not subject to pre-service review.		
	in a medicare-approved demonstration project)			
G9116	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	of disease progression, or recurrence, and/or platinum resistance (for use in a	Plan. Not subject to pre-service review.		
	medicare-approved demonstration project)	, '		
G9117	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	disease unknown, staging in progress, or not listed (for use in a medicare-	Plan. Not subject to pre-service review.		
	approved demonstration project)	, ,		
G9123	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	chromosome positive and/or bcr-abl positive; chronic phase not in hematologic,	Plan. Not subject to pre-service review.		
	cytogenetic, or molecular remission (for use in a medicare-approved			
	5,15g5.16tic, of molecular formecian (for doc in a modical approved			

G9124	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia	Non Covered: Precedura/service not covered by the	1/1/2006	12/31/2999
G9124	chromosome positive and/or bcr-abl positive; accelerated phase not in	Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
	hematologic cytogenetic, or molecular remission (for use in a medicare-approved			
	demonstration project)			
G9125	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	chromosome positive and/or bcr-abl positive; blast phase not in hematologic,	Plan. Not subject to pre-service review.		
	cytogenetic, or molecular remission (for use in a medicare-approved			
	demonstration project)			
G9126	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia		1/1/2006	12/31/2999
	chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or	Plan. Not subject to pre-service review.		
	molecular remission (for use in a medicare-approved demonstration project)			
G9129	Oncology; disease status; limited to multiple myeloma, systemic disease; stage in	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	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; extent	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	of disease unknown, staging in progress, or not listed (for use in a medicare-	Plan. Not subject to pre-service review.		
	approved demonstration project)			
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	(DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA	Plan. Not subject to pre-service review.		
	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
	ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-	Plan. Not subject to pre-service review.		
	INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR			
	POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE	1		
G9133	APPROVED DEMONSTRATION PROJECT) ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
Garss	ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES	Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
	OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED	Plan. Not subject to pre-service review.		
	DEMONSTRATION PROJECT)			
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
00101	CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED,	Plan. Not subject to pre-service review.	17 172007	12/01/2000
	NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED			
	DEMONSTRATION PROJECT)			
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	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 DEMONSTRATION			
	PROJECT)			
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 SECOND	Plan. Not subject to pre-service review.		
	CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED			
	DEMONSTRATION PROJECT)			
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A	Plan. Not subject to pre-service review.		
	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
	CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE	Plan. Not subject to pre-service review.		
	TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED			
	DEMONSTRATION PROJECT)			
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA,	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL	Plan. Not subject to pre-service review.		
	POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS,			
	NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION			
00440	PROJECT)		4/4/0000	10/04/0000
G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	·	Plan. Not subject to pre-service review.		
	THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE			
	EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A			
	CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE			
	PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A			
	MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48			
	HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS			
	PREVENT TRANSFER: PAYMENT IS MADE ON EACH PERIOD UP TO 4			
	HOURS, AFTER THE FIRST 4 HOURS			
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	by any means, guided by the results of measurements for:respiratory quotient;	subject to pre-service review. Check EIU policy, which		
	and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose;	is one of our Clinical Payment and Coding Policy		
	and/or potassium concentration	(CPCP).		
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	by any means, guided by the results of measurements for:respiratory quotient;	subject to pre-service review. Check EIU policy, which		
	and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	is one of our Clinical Payment and Coding Policy (CPCP).		
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
00172	Injustion, addodinands avwa, 2 mg	Medical Policy Criteria. Submit for Recommended	17 172022	12/01/2000
		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		
10.170		Clinical Review to avoid post-service review.	011510000	10/04/0000
J0178	Injection, aflibercept, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
J0179	Injection, brolucizumab-dbll, 1 mg	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
30178	injection, protuctzumap-upit, i my	Medical Policy Criteria. Submit for Recommended	0/10/2023	12/3 1/2999
		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		3.0.7202
		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 SPECIFIED	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		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.		
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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0485	Injection, belatacept, 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.		
J0491	Injection, anifrolumab-fnia, 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.		
J0517	Injection, benralizumab, 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.		
J0565	Injection, bezlotoxumab, 10 mg	MP Criteria: Procedure/service reviewed against	1/1/2018	3/14/2024
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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.		
	I	Chilliodi i Covicivi to avoid post-service review.	<u> </u>	1

J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
J0600		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	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 drug	MP Criteria: Procedure/service reviewed against	1/1/2014	6/14/2024
		Medical Policy Criteria. Submit for Recommended		
	self administered)	Clinical Review to avoid post-service review.		
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-	MP Criteria: Procedure/service reviewed against	10/15/2023	3/14/2024
	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 MG	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.		
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
		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
		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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1304	Injection, tofersen, 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.		
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1306	Injection, inclisiran, 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.		
J1325	Injection, epoprostenol, 0. 5 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.		

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		
		Clinical Review to avoid post-service review.		
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	10^13 vector genomes	Medical Policy Criteria. Submit for Recommended		
	· · · · · · · · · · · · · · · · · · ·	Clinical Review to avoid post-service review.		
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	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.		
J1426	Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1427	Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	, · · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1428	Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1429	Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	,, g, . <b></b> g	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1440	Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed against	6/1/2024	12/31/2999
	January January 1	Medical Policy Criteria. Submit for Recommended	0, 1,202 .	1.276 172000
		Clinical Review to avoid post-service review.		
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	injection, initially growth (catalyting), rooming	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
J1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	injousin, initially greature (accelling)	Medical Policy Criteria. Submit for Recommended	., .,	1.276 172000
		Clinical Review to avoid post-service review.		
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid),	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
0.0.0	500 mg	Medical Policy Criteria. Submit for Recommended	0, 1,2020	1.276 172000
	ooo mg	Clinical Review to avoid post-service review.		
J1632	Injection, brexanolone, 1 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.		
J1675	INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS	MP Criteria: Procedure/service reviewed against	1/1/2006	3/14/2024
0.0.0		Medical Policy Criteria. Submit for Recommended	., .,	6, 1, 1, 202 .
		Clinical Review to avoid post-service review.		
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the	7/15/2023	12/31/2999
00	, Joseph J. (	Plan. Not subject to pre-service review.	1,10,2020	1.276 172000
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Non Covered: Procedure/service not covered by the	7/15/2023	12/31/2999
0.120		Plan. Not subject to pre-service review.	1710/2020	12,01,2000
J1746	Injection, ibalizumab-uiyk, 10 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	3/31/2024
	injusticity wanted dryft, 10 mg	Medical Policy Criteria. Submit for Recommended	., 1, 2010	5.5 1/252 1
		Clinical Review to avoid post-service review.		
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against	5/1/2023	12/31/2999
V 1.1 T1	injustion, opposition obzo, i my	Medical Policy Criteria. Submit for Recommended	0, 1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
	ı	Tominoai ineview to avoid post-service review.		

J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1930	INJECTION, LANREOTIDE, 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.		
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	1
		Clinical Review to avoid post-service review.		
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		1
		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
<b>0</b> 0.		Medical Policy Criteria. Submit for Recommended	0, 1,202	.=, 0 :, = 000
		Clinical Review to avoid post-service review.		
J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM	MP Criteria: Procedure/service reviewed against	11/1/2006	5/31/2024
022.0	indestron, Electronist, Timorrectum	Medical Policy Criteria. Submit for Recommended	11/1/2000	0/01/2021
		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
02021	injection, nearitizathab-izaa, initaveneas, 1 mg	Medical Policy Criteria. Submit for Recommended	17 172023	12/01/2000
		Clinical Review to avoid post-service review.		
J2329	Injection, ublituximab-xiiy, 1mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
02029	injection, ubilituximab-xily, img	Medical Policy Criteria. Submit for Recommended	0/13/2023	12/31/2999
		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
J2333	Injection, octreotide, deportionn for intramuscular injection, it my	Medical Policy Criteria. Submit for Recommended	4/1/2024	12/3 1/2999
		Clinical Review to avoid post-service review.		
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection,	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
J2334		Medical Policy Criteria. Submit for Recommended	4/1/2024	12/3 1/2999
	25 mcg	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
J2330	injection, tezepelumap-ekko, i mg	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
J2502	Injection, pasireotide long acting, 1 mg	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2016	4/30/2024
J2302	injection, pasireotide long acting, 1 mg	_	1/ 1/2010	4/30/2024
		Medical Policy Criteria. Submit for Recommended		
J2508	Injection popularical aidean alfa juni 1 mg	Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J2306	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/3 1/2999
		Medical Policy Criteria. Submit for Recommended		
10777	Inication feminimals area 0.4 mm	Clinical Review to avoid post-service review.	10/1/2022	40/04/0000
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		
10770	INTECTION DANIBIZATIVAD O 4 MC	Clinical Review to avoid post-service review.	0/45/0000	40/04/0000
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10770		Clinical Review to avoid post-service review.	7/4/0000	40/04/0000
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-aqqg, 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.		
J3121	Injection, testosterone enanthate, 1mg	MP Criteria: Procedure/service reviewed against	1/1/2015	3/14/2024
		Medical Policy Criteria. Submit for Recommended		
		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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3241	Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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.		
J3299	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.		
J3393	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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	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.		
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector	MP Criteria: Procedure/service reviewed against	7/1/2020	12/31/2999
	genomes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	10^9 pfu/ml vector genomes, per 0.1 ml	Medical Policy Criteria. Submit for Recommended		
	3 71 1	Clinical Review to avoid post-service review.		
J3520	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.		
J3570	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
	7 7 7 7	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J7178	Injection, human fibrinogen concentrate, not otherwise specified, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2013	6/30/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	I.U. VWF:RCO	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	MP Criteria: Procedure/service reviewed against	6/15/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
0.0.0	injection, necessions accounted, material car implant (necessity, coor mg	Medical Policy Criteria. Submit for Recommended	., ., _ 0 . 0	12/01/2000
		Clinical Review to avoid post-service review.		
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
07001	injocion, simacoprost, intrasamoral implant, 1 morogram	Medical Policy Criteria. Submit for Recommended	10/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J7355	Injection, travoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
01000	injocion, autoproot, madoamora impiant, i morogram	Medical Policy Criteria. Submit for Recommended	17 172021	12/01/2000
		Clinical Review to avoid post-service review.		
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
0,001	ADMINISTERED THROUGH	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	ABILITY OF THE STATE OF THE STA	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH	subject to pre-service review. Check EIU policy, which		1
	ASMINISTERES THROUGH	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	subject to pre-service review. Check EIU policy, which	, .,	12/01/2000
	7.5	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	subject to pre-service review. Check EIU policy, which	, 1,2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	subject to pre-service review. Check EIU policy, which	, 1,2020	12/01/2000
	ASSISTANCE LED THROUGH DIME, ONTO DOOL, TWO	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		I(UF UF ).		

J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
07009	ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/3 1/2999
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
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	12/1/2020	12/31/2999
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	(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
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM		, .,_0_0	1270 172000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, 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. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	subject to pre-service review. Check EIU policy, 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. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
170.40	OLYGODY/DDGLATE INHALATION COLUTION COMPOUNDED DDGDLIGT	(CPCP).	40/4/0000	10/04/0000
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	10/1/0000	12/31/2999
J704Z	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM		12/1/2020	12/31/2999
	ADMINISTERED THROUGH DIME, CONCENTRATED FORM, FER MILLIGRAM	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which	/ 1/2020	12,01,2000
	ABMINIOTERED THROUGH BIME, ONLY BOOK FORM, FERTIMETION WI	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
	,,,	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	subject to pre-service review. Check EIU policy, which		
	MILLIGRAM	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	, .,,	1.2/0./2000
	MILLIGRAM	(CPCP).		
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM			
		is one of our Clinical Payment and Coding Policy		
170.47		(CPCP).	101110000	10/01/0000
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
37037	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER		12/1/2020	12/3 1/2999
	MILLIGRAM	is one of our Clinical Payment and Coding Policy		
	IWILLIOTON	(CPCP).		
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER			
	MILLIGRAM	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	subject to pre-service review. Check EIU policy, which		
	MILLIGRAM	is one of our Clinical Payment and Coding Policy (CPCP).		
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
07000	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
	MILLIGRAM	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
J7667	METADDOTEDENOL CHILEATE INILIALATION COLLITION COMPOUNDED	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2020	12/21/2000
J/00/	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
	I NODUCI, CONCENTRATED I ORIVI, PER 10 WILLIGRAWIO	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10	subject to pre-service review. Check EIU policy, which		
	MILLIGRAMS	is one of our Clinical Payment and Coding Policy		
		(CPCP).		

J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
01010	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12,11,2020	12/0 1/2000
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7680	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
J7680	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7681	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7681	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS			
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
	3,1	Medical Policy Criteria. Submit for Recommended		
		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
		Plan. Not subject to pre-service review.		
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
1		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		
		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		
		Clinical Review to avoid post-service review.		
K0011	Standard - weight frame motorized/power wheelchair with programmable control	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	parameters for speed adjustment, tremor dampening, acceleration control and	Medical Policy Criteria. Submit for Recommended		
	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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against	7/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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 strength,	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	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 medication, (e.	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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.		
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, HOME	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
	MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
	MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPACITY, 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
	112.5 5.117.6 10.000	Clinical Review to avoid post-service review.		
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	,.,,	1.2.3.7.2.3.3
		Clinical Review to avoid post-service review.		
K0812	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.		
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
50 10	SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300		13/ 1/2000	12,0 1,2000
	POUNDS	Clinical Review to avoid post-service review.		
	ILOUNDO	Tollilloal Neview to avoid post-service review.		

K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS		,.,,	1.2.3.2.3.2
		Clinical Review to avoid post-service review.		
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300	Medical Policy Criteria. Submit for Recommended		
	POUNDS	Clinical Review to avoid post-service review.		
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria, Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK,	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.		
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, 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.		
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0826	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.		
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	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.		
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION,	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.		

K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		1.2
	300 POUNDS	Clinical Review to avoid post-service review.		
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450	Medical Policy Criteria. Submit for Recommended		
	POUNDS	Clinical Review to avoid post-service review.		
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO	Medical Policy Criteria. Submit for Recommended		
	600 POUNDS	Clinical Review to avoid post-service review.		
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601	Medical Policy Criteria. Submit for Recommended		
	POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION,	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.		
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO	Medical Policy Criteria. Submit for Recommended		
	450 POUNDS	Clinical Review to avoid post-service review.		
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK,	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.		
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, 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.		
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		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
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		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
	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
	The state of the s	Clinical Review to avoid post-service review.		
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended	122000	
	TABLE TO THE ONLY NOTE OF THE ONLY	Clinical Review to avoid post-service review.		
	ı	Official Review to avoid post-service review.		

K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION,	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	,.,,	1.2.3.2.3.2
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450	Medical Policy Criteria. Submit for Recommended	,.,,	1.2.3.2.3.2
	POUNDS	Clinical Review to avoid post-service review.		
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO	Medical Policy Criteria. Submit for Recommended	,.,,	1.2.3.2.3.2
	600 POUNDS	Clinical Review to avoid post-service review.		
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION,	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	,.,=====	1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO	Medical Policy Criteria. Submit for Recommended	10, 1,2000	12/01/2000
	450 POUNDS	Clinical Review to avoid post-service review.		
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	600 POUNDS	Clinical Review to avoid post-service review.		
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1,0001	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110000	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	TATIENT WEIGHT GALACITY OF TO AND INCEODING 6001 GONDO	Clinical Review to avoid post-service review.		
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1,0000	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	WEIGHT GALAGITT OF TO AND INCEODING 500 TOURDS	Clinical Review to avoid post-service review.		
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1.0070	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	TATIENT WEIGHT GALAGIT GOT TO 400 T GOTNEG	Clinical Review to avoid post-service review.		
K0871	POWER WHEELCHAIR, GROUP 4 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	10/1/2000	12/01/2000
	SEATISTICIA, FAMELA MEISTIN SALAGON FOR TO SOUT SOURS	Clinical Review to avoid post-service review.		
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION,	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	10/1/2000	12/01/2000
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended	13, 2000	1.2,5 .,255
	300 POUNDS	Clinical Review to avoid post-service review.		
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450	Medical Policy Criteria. Submit for Recommended	13/ 1/2000	12,5 1,2555
	POUNDS	Clinical Review to avoid post-service review.		
	II COMPO	Tominoal Neview to avoid post-service leview.		

K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS			
		Clinical Review to avoid post-service review.		
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION,	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.		
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300	Medical Policy Criteria. Submit for Recommended		
	POUNDS	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
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO	Medical Policy Criteria. Submit for Recommended		
	450 POUNDS	Clinical Review to avoid post-service review.		
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION,	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 125 POUNDS	Clinical Review to avoid post-service review.		
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION,	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 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		
144004		Clinical Review to avoid post-service review.	101110000	10/01/0000
K1004	Low frequency ultrasonic diathermy treatment device for home use	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
K1004	Low frequency ultrasonic diathermy treatment device for home use	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
144007		(CPCP).	0/4/0004	10/01/0000
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component,	EIU: Procedure/service not reimbursed by the Plan. Not	3/1/2021	12/31/2999
	single or double upright(s), knee joints any type, with or without ankle joints any	subject to pre-service review. Check EIU policy, which		
	type, includes all components and accessories, motors, microprocessors,	is one of our Clinical Payment and Coding Policy		
1/4007	sensors	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	0/4/0004	40/04/0000
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component,		3/1/2021	12/31/2999
	single or double upright(s), knee joints any type, with or without ankle joints any	subject to pre-service review. Check EIU policy, which		
	type, includes all components and accessories, motors, microprocessors,	is one of our Clinical Payment and Coding Policy		
K1027	sensors  Oral device/appliance used to reduce upper airway collapsibility, without fixed	(CPCP). MP Criteria: Procedure/service reviewed against	10/1/2021	7/31/2024
K1027		Medical Policy Criteria. Submit for Recommended	10/1/2021	7/31/2024
	mechanical hinge, custom fabricated, includes fitting and adjustment	1		
K1030	External recharging system for battery (internal) for use with implanted cardiac	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
1030	contractility modulation generator, replacement only	Medical Policy Criteria. Submit for Recommended	4/ 1/2022	12/31/2999
	Contractility modulation generator, replacement only	Clinical Review to avoid post-service review.		
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2022	12/31/2999
111000	diathermy treatment device, per month	subject to pre-service review. Check EIU policy, which	10/1/2023	12/31/2999
	diamenny heatment device, per month	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		I(UFUF).		

K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2023	12/31/2999
111000	diathermy treatment device, per month	subject to pre-service review. Check EIU policy, which	10/1/2020	12/01/2000
	diatherny treatment device, per month	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
K1037	Docking station for use with oral device/appliance used to reduce upper airway	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	collapsibility	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
K1037	Docking station for use with oral device/appliance used to reduce upper airway	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	collapsibility	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
K1037	Docking station for use with oral device/appliance used to reduce upper airway	MP Criteria: Procedure/service reviewed against	9/15/2024	9/30/2024
	collapsibility	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		121211222
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	frame with anterior and posterior rigid pads, custom fabricated	Medical Policy Criteria. Submit for Recommended		
1.400.4	IZ	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
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		
1.4040	Variable de la contration de la contrati	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	fabricated	Medical Policy Criteria. Submit for Recommended		
L1844	MALE ORTHOGIC CINCLE LIPPICHT THICH AND CALE WITH	Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
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 POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR	Medical Policy Criteria. Submit for Recommended		
	WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	Clinical Review to avoid post-service review.		
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
L1040	ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1950	12/31/2999
	POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR	Clinical Review to avoid post-service review.		
	WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	Cililical Review to avoid post-service review.		
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	,,,,, <del>g</del> , <del>g</del>	Plan. Not subject to pre-service review.	,	1.2.5.11.2.5.5
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, hydracadence	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 disarticulation,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 swing	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	and stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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.		
_5624	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.		
_5631	Addition to lower extremity, above knee or knee disarticulation, 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.		
_5638	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.		
_5639	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.		
_5644	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.		
_5645	Addition to lower extremity, below knee, flexible inner socket, external frame	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.		
_5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion 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.		
_5647	Addition to lower extremity, below knee suction 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.		
_5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion 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.		
_5651	Addition to lower extremity, above knee, flexible inner socket, external frame	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

L5652	Addition to lower extremity, suction suspension, above knee or knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation socket	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ('pts'	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	or similar)	Medical Policy Criteria. Submit for Recommended		
	, , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
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		
		Clinical Review to avoid post-service review.		
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		
		Clinical Review to avoid post-service review.		
L5710	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-light	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 stance	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.		
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction 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.		
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control	Medical Policy Criteria. Submit for Recommended		
	<b>'</b>	Clinical Review to avoid post-service review.		
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction	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.		
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	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	
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control	Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
i	phase control	Medical Policy Criteria. Submit for Recommended		
	P	Clinical Review to avoid post-service review.	1	1

L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	swing phase control	Medical Policy Criteria. Submit for Recommended		
	8 h	Clinical Review to avoid post-service review.		
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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, carbon	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 (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.		
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-light	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	material	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control (safety knee)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance	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.		
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction	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.		
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	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.		
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	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 stance	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.		
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/ 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.		
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
-	swing phase control	Medical Policy Criteria. Submit for Recommended		
	J F	Clinical Review to avoid post-service review.		

L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
	Station primary	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 ADJUSTABILITY	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND	Medical Policy Criteria. Submit for Recommended		
	STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	Clinical Review to avoid post-service review.		
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE	Medical Policy Criteria. Submit for Recommended		
	ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	Clinical Review to avoid post-service review.		
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	and programmable flexion/extension assist control, includes any type motor(s)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	knee, hip disarticulation, positional rotation unit, any type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR	Medical Policy Criteria. Submit for Recommended		
	WITHOUT FLEXION AND/OR EXTENSION CONTROL	Clinical Review to avoid post-service review.		
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	covering system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	covering system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5966	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		
		Clinical Review to avoid post-service review.		
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active	MP Criteria: Procedure/service reviewed against	4/15/2015	12/31/2999
	dorsiflexion feature	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	type motor(s)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5970	All lower extremity prostheses, foot, external keel, sach 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.		
L5972	All lower extremity prostheses, foot, flexible keel	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.		
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION	Medical Policy Criteria. Submit for Recommended		
	CONTROL, INCLUDES POWER SOURCE	Clinical Review to avoid post-service review.		
L5974	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		
		Clinical Review to avoid post-service review.		

L5976	All lower extremity prostheses, energy storing foot (seattle carbon copy ii or	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	equal)	Medical Policy Criteria. Submit for Recommended		
1.5070		Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
L5978	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.		
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	piece system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5980	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.		
L5981	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.		
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 without	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	adjustability	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
	adjustasiirty	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
20000	7 iii chaosholotal lower extremity prostriosos, ayriamie prostriotie pylon	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		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
L3900	All lower extremity prostrieses, multi-axial rotation unit (mop of equal)	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/3 1/2999
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon	Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5987	All lower extremity prostnesis, snank loot system with vertical loading pylon	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
. = 0.0 /		Clinical Review to avoid post-service review.	101110000	10/01/0000
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2023	12/31/2999
	connector	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2023	12/31/2999
	connector	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 power,	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	self-suspended, inner socket with removable forearm section, electrodes and	Medical Policy Criteria. Submit for Recommended		
	cables, two batteries, charger, myoelectric control of terminal device, excludes	Clinical Review to avoid post-service review.		
	terminal device(s)	, '		
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	ADDITIONAL SWITCH, ANY TYPE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L6621	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED	Medical Policy Criteria. Submit for Recommended		12,5 1,2555
	TERMINAL DEVICE	Clinical Review to avoid post-service review.		
	I LIMMINAL DEVICE	Tominoar Neview to avoid post-service review.	I	

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	Medical Policy Criteria. Submit for Recommended		
	COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	Clinical Review to avoid post-service review.		
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device	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.		
L6920	Wrist disarticulation, 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, switch, cables, two batteries and one charger,	Medical Policy Criteria. Submit for Recommended		
	switch control of terminal device	Clinical Review to avoid post-service review.		
L6925	Wrist disarticulation, 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	Medical Policy Criteria. Submit for Recommended		
	charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6930	Below elbow, external power, self-suspended inner socket, removable forearm	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shell, otto bock or equal switch, cables, two batteries and one charger, switch	Medical Policy Criteria. Submit for Recommended		
	control of terminal device	Clinical Review to avoid post-service review.		
L6935	Below elbow, external power, self-suspended inner socket, removable forearm	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shell, otto bock or equal electrodes, cables, two batteries and one charger,	Medical Policy Criteria. Submit for Recommended		1-7-1-1-1-1
	myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shell, outside locking hinges, forearm, otto bock or equal switch, cables, two	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
	batteries and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
20010	shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	batteries and one charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6950	Above elbow, external power, molded inner socket, removable humeral shell,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
20000	internal locking elbow, forearm, otto bock or equal switch, cables, two batteries	Medical Policy Criteria. Submit for Recommended	4/ 1/2000	12/01/2000
	and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
L6955	Above elbow, external power, molded inner socket, removable humeral shell,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
20000	internal locking elbow, forearm, otto bock or equal electrodes, cables, two	Medical Policy Criteria. Submit for Recommended	4/ 1/2000	12/01/2000
	batteries and one charger, myoelectronic control of terminal device	Clinical 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
20000	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm,	Medical Policy Criteria. Submit for Recommended	4/ 1/2000	12/01/2000
	otto bock or equal switch, cables, two batteries and one charger, switch control	Clinical Review to avoid post-service review.		
	of terminal device	Cililical Neview to avoid post-service review.		
L6965	Shoulder disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0303	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm,	Medical Policy Criteria. Submit for Recommended	4/1/2003	12/01/2000
	otto bock or equal electrodes, cables, two batteries and one charger,	Clinical Review to avoid post-service review.		
	myoelectronic control of terminal device	Cililical Neview to avoid post-service review.		
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0970	shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock	<del>-</del>	4/1/2009	12/3 1/2999
		Clinical Review to avoid post-service review.		
	device	Cliffical Review to avoid post-service review.		
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L03/3	shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock		7/1/2003	12/3 1/2999
	or equal electrodes, cables, two batteries and one charger, myoelectronic control			
	of terminal device	Cililical Neview to avoid post-service review.		
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L1001	ELLOTRIO HAIND, SWITCH OR WITCELEGTRIC CONTROLLED, ADULT	ŭ	4/ 1/2009	12/3 1/2999
		Medical Policy Criteria. Submit for Recommended		
	I	Clinical Review to avoid post-service review.		

L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	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.	4/1/2009	12/31/2999
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7170	Electronic elbow, hosmer or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7259	Electronic wrist rotator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7360	Six volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7362	Battery charger, six volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7366	Battery charger, twelve volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

L7367	Lithium ion battery, rechargeable, replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2007	12/31/2999
L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	5/14/2024
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		9/14/2024
L8609	ARTIFICIAL CORNEA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999

L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/15/2023	12/31/2999
	<u>'</u>	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 IMPLANTABLE	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR,	Medical Policy Criteria. Submit for Recommended		
	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 neurostimulator	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	radiofrequency receiver	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	includes extension	Medical Policy Criteria. Submit for Recommended		1
	Indiado oxionor	Clinical Review to avoid post-service review.		
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
20001	extension	Medical Policy Criteria. Submit for Recommended	17 172022	12/01/2000
	CACHSION	Clinical Review to avoid post-service review.		
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
20000	includes extension	Medical Policy Criteria. Submit for Recommended	17 172022	12/01/2000
	Indiddes extension	Clinical Review to avoid post-service review.		
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
20000	WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	Medical Policy Criteria. Submit for Recommended	1710/2020	12/01/2000
	WITH IN LANTABLE NEOROSTINGLATOR, REFEACEMENT ONET	Clinical Review to avoid post-service review.		
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
L0034	Additory osseonitegrated device, transducer/actuator, replacement only, each	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
		Clinical Review to avoid post-service review.		
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE	MP Criteria: Procedure/service reviewed against	9/19/2022	12/31/2999
L0033	WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	Medical Policy Criteria. Submit for Recommended	3/13/2022	12/01/2000
	WITH IN LANTABLE NEOROSTINGLATOR, REFEACEMENT ONET	Clinical Review to avoid post-service review.		
L8698	Miscellaneous component, supply or accessory for use with total artificial heart	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
L0030	system	Medical Policy Criteria. Submit for Recommended	17 172013	12/01/2000
	System	Clinical Review to avoid post-service review.		
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	single or double upright(s), includes microprocessor, sensors, all components	Medical Policy Criteria. Submit for Recommended	1, 1,2010	12/01/2000
	and accessories, custom fabricated	Clinical Review to avoid post-service review.		
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
L0102	finger, single or double upright(s), includes microprocessor, sensors, all	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/01/2000
	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
1410070	осния инстару	· ·	1/1/1930	12/31/2000
		Plan. Not subject to pre-service review.		

M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
10070	Tolothorapy	subject to pre-service review. Check EIU policy, which	1/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
WOO7 O	1 Tolothorapy	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
		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
IVIO 100	Thin agastric Hypotherinia using gastric recently	Plan. Not subject to pre-service review.	17 17 1330	12/01/2333
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
WIOZ-TO	includes infusion or injection, and post administration monitoring, subsequent	subject to pre-service review. Check EIU policy, which	0/1/2020	12/01/2000
	repeat doses	is one of our Clinical Payment and Coding Policy		
	Topout dood	(CPCP).		
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring, subsequent	subject to pre-service review. Check EIU policy, which	07 172020	12/01/2000
	repeat doses	is one of our Clinical Payment and Coding Policy		
	Topour dood	(CPCP).		
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring in the home or	subject to pre-service review. Check EIU policy, which		
	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	(CPCP).		
	doses	(6. 6. 7.		
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring in the home or	subject to pre-service review. Check EIU policy, which		
	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	(CPCP).		
	doses	,		
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring in the home or	subject to pre-service review. Check EIU policy, which		
	residence; this includes a beneficiary's home that has been made provider-based	•		
	to the hospital during the covid-19 public health emergency	(CPCP).		
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	includes infusion or injection, and post administration monitoring in the home or	subject to pre-service review. Check EIU policy, which		
	residence; this includes a beneficiary's home that has been made provider-based			
	to the hospital during the covid-19 public health emergency	(CPCP).		
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	administration monitoring	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2022	12/31/2999
1010243	·	subject to pre-service review. Check EIU policy, which	0/1/2023	12/3 1/2999
	administration monitoring			
		is one of our Clinical Payment and Coding Policy (CPCP).		
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	administration monitoring in the home or residence; this includes a beneficiary's	subject to pre-service review. Check EIU policy, which		
	home that has been made provider based to the hospital during the covid 19	is one of our Clinical Payment and Coding Policy		
	public health emergency	(CPCP).		
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
	administration monitoring in the home or residence; this includes a beneficiary's	subject to pre-service review. Check EIU policy, which		
	home that has been made provider based to the hospital during the covid 19	is one of our Clinical Payment and Coding Policy		
	public health emergency	(CPCP).		12/2/22
M0300	Iv chelation therapy (chemical endarterectomy)	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.		
M0301	Fabric wrapping of abdominal aneurysm	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
Doogo		Plan. Not subject to pre-service review.	4/4/4050	10/04/0000
P2029	Congo red, blood	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
D0004	Halla and halla (and halla a and halla)	Plan. Not subject to pre-service review.	0/04/0040	40/04/0000
P2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
D0000	District wish wishes a society with	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not	40/4/0000	40/04/0000
P9020	Platelet rich plasma, each unit		12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
P9020	Platelet rich plasma, each unit	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
P9020	Platelet fich plasma, each unit	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
P9603	Travel allowance one way in connection with medically necessary laboratory	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
. 5555	specimen collection drawn from home bound or nursing home bound patient;	Plan. Not subject to pre-service review.	., ., .,	1.276 172888
	prorated miles actually travelled			
P9604	Travel allowance one way in connection with medically necessary laboratory	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	specimen collection drawn from home bound or nursing home bound patient;	Plan. Not subject to pre-service review.		
	prorated trip charge.	ĺ '		
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. Not	6/1/2023	12/31/2999
		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. Not	6/1/2023	12/31/2999
		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. Not	6/1/2023	12/31/2999
		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. Not	6/1/2023	12/31/2999
Q0240	Injection, casinvinab and indevinab, 2400 mg	subject to pre-service review. Check EIU policy, which	0/1/2023	12/31/2999
		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. No	6/1/2023	12/31/2999
Q0244	Injection, casinvinab and indevinab, 1200 mg	subject to pre-service review. Check EIU policy, which	0/1/2023	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		,		
Q0244	Injustice assistance and instrument 4000 mm	(CPCP). EIU: Procedure/service not reimbursed by the Plan. No	0/4/0000	12/31/2999
Q0244	Injection, casirivimab and imdevimab, 1200 mg		6/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00045	Indication to an incident and attack and a to a color of	(CPCP).	0/4/0000	40/04/0000
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00045		(CPCP).	0/4/0000	10/01/0000
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not	6/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00400		(CPCP).	10/1/0005	10/01/0000
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, replacement	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	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 ventricular	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	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 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.		
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular	MP Criteria: Procedure/service reviewed against	10/1/2005	12/31/2999
	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, vehicle		10/1/2005	12/31/2999
	type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0510	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S),	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	FIRST MONTH FOLLOWING transPLANT	Plan. Not subject to pre-service review.		
Q0511	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A	Plan. Not subject to pre-service review.		
	30-DAY PERIOD			

Q0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive		1/1/2006	12/31/2999
	drug(s); for a subsequent prescription in a 30-day period	Plan. Not subject to pre-service review.		
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
	prescription oral drug, per 30-days	Plan. Not subject to pre-service review.		
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.		
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.		
Q2026	INJECTION, RADIESSE, 0.1 ML	MP Criteria: Procedure/service reviewed against	8/15/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		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 positive	MP Criteria: Procedure/service reviewed against	4/1/2018	12/31/2999
	viable t cells, including leukapheresis and dose preparation procedures, per	Medical Policy Criteria. Submit for Recommended		
	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
~	leukapheresis and dose preparation procedures, per therapeutic dose	Medical Policy Criteria. Submit for Recommended	., .,	12,01,2000
	Tournaprior colo arra acco proparation procedures, por triorapoutto acco	Clinical Review to avoid post-service review.		
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	Non Covered: Procedure/service not covered by the	4/1/2024	12/31/2999
Q2010	Injection, Boxorabion Tryarosinonas, Especialis, Importos Especiax, To mg	Plan. Not subject to pre-service review.	17 172021	12/01/2000
Q2052	Services, supplies, and accessories used in the home for the administration of	Non Covered: Procedure/service not covered by the	4/1/2014	12/31/2999
QLUUL	intravenous immune globulin (ivig)	Plan. Not subject to pre-service review.	17 172011	12/01/2000
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
QLUUU	viable t cells, including leukapheresis and dose preparation procedures, per	Medical Policy Criteria. Submit for Recommended	17 172021	12/01/2000
	therapeutic dose	Clinical Review to avoid post-service review.		
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
Q2004	viable t cells, including leukapheresis and dose preparation procedures, per	Medical Policy Criteria. Submit for Recommended	10/1/2021	12/01/2000
	therapeutic dose	Clinical Review to avoid post-service review.		
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
QZ000	(bcma) directed car-positive t cells, including leukapheresis and dose preparation		17 172022	12/01/2000
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
Q2000	(bcma) directed car-positive t cells, including leukapheresis and dose preparation		10/1/2022	12/31/2999
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
Q4002	COMPETITIVE ACQUISITION PROGRAM (CAP)	Plan. Not subject to pre-service review.	1/ 1/2007	12/31/2999
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q+100	ONIN SOBSTITUTE, NOT OTHERWISE SPECIFIED	Medical Policy Criteria. Submit for Recommended	11/13/2020	12/31/2333
		Clinical Review to avoid post-service review.		
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q+101	ALLIGITAL, FEIT OQUAINE CENTIIVIETEN		11/13/2020	12/31/2333
		Medical Policy Criteria. Submit for Recommended		
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	Clinical Review to avoid post-service review.	11/15/2020	12/21/2000
Q4 102	UASIS WOUND MATRIX, 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.		

Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q+100	OAGIO BORIVINATION, I ER OQUARE OLIVINIETER	subject to pre-service review. Check EIU policy, which	5/15/2021	12/01/2000
		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. Not	5/15/2021	12/31/2999
Q+100	ONOIS BOTTO WITHIN, I EN OGOTAL SERVINETEN	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Δ	CENTIMETER (2007)	subject to pre-service review. Check EIU policy, which	07.07202.	12/01/2000
	<u> </u>	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	CENTIMETER	subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
	regeneration matrix, per square centimeter	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4106	DERMAGRAFT, 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.		
Q4107	GRAFTJACKET, 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.		
Q4108	INTEGRA MATRIX, 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.		
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04444	OANIMA OBAET, DED COLLADE OFNTINETED	(CPCP).	E/4E/0004	40/04/0000
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q4111	GAIVINAGRAFT, FER SQUARE CENTIMETER	subject to pre-service review. Check EIU policy, which	3/ 13/2021	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q+11Z	OTIVILITIA, INSECTABLE, TOO	subject to pre-service review. Check EIU policy, which	3/ 13/2021	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		[(UFUF).		

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

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 centimeter	MP Criteria: Procedure/service reviewed against	10/15/2021	12/31/2999
		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. No	t 5/15/2021	12/31/2999
		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. No	t 5/15/2021	12/31/2999
		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 CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. No	t 5/15/2021	12/31/2999
		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 CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. No	t 5/15/2021	12/31/2999
		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. No	t 5/15/2021	12/31/2999
		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. No	t 5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4400		(CPCP).	1 5/45/0004	10/01/0000
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. No	t 5/15/2021	12/31/2999
		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. No	+ 5/15/2021	12/31/2999
Q4 120	iniemoderni, derniaspan, tranzgraft or integupty, per square centimeter	subject to pre-service review. Check EIU policy, which	1 3/13/2021	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. No	t 5/15/2021	12/31/2999
QT IZI	TALTIMED, I EILOQUAILE OLIVIIIVILTEIL	subject to pre-service review. Check EIU policy, which	0/10/2021	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. No	t 5/15/2021	12/31/2999
~ 1 121		subject to pre-service review. Check EIU policy, which	10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
~1120	. 15% ray, or unopator ray, por oquaro continuotor	Medical Policy Criteria. Submit for Recommended	. 1, 10,2020	12/01/2000
		Clinical Review to avoid post-service review.		
		Towns and the state of the poor out the fortier.	1	1

Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q+100	OTTATTIOE TWI, I ER OQUARE OER TIMETER	subject to pre-service review. Check EIU policy, which	0/10/2021	12/3 1/2333
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	subject to pre-service review. Check EIU policy, 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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	7/31/2024
		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
		Medical Policy Criteria. Submit for Recommended		
l		Clinical Review to avoid post-service review.		

Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q4130	blodience drynex, per square certimeter	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04444	All I'	(CPCP).	10/04/0000
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4142	Xcm biologic tissue matrix, per square centimeter	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
Q4 142	Acm biologic tissue matrix, per square centimeter	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4142	Xcm biologic tissue matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
QT ITZ	Non biologic assuc matrix, per square certameter	subject to pre-service review. Check EIU policy, which	12/3 1/2333
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	, 5 ., _ 5 5
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
ς.,,ο	1. top	subject to pre-service review. Check EIU policy, which	.2/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
		Not of J.	

Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
QT 1TO	Epinx, injectable, 1 mg	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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 centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		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 centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.44.40	Ni ana and dia mana and dia ana danka and dia mana and dia mana and dia mana and dia mana and dia mana and dia	(CPCP).	40/4/0000	40/04/0000
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	5/15/2021	12/31/2999
Q4149	Excellageri, 0.1 cc	subject to pre-service review. Check EIU policy, which	5/15/2021	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
QT 1TJ	Excellegen, v. 1 co	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	, 1,2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
<u> </u>		subject to pre-service review. Check EIU policy, which	, 1,2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		I(O) O) j.		

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.	
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.1454	Discourse and the state of the	(CPCP).	40/04/0000
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against  8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended	
04155	Negytle or elevistle 1 mg	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q4155	Neoxflo or clarixflo, 1 mg	· · · · · · · · · · · · · · · · · · ·	12/31/2999
		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. Not 12/1/2020	12/31/2999
Q+100	THEOMIC OF CIGHTAINS, 1 HIS	subject to pre-service review. Check EIU policy, which	12/01/2000
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	1
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.4450		(CPCP).	10/04/0000
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		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. Not 5	5/15/2021	12/31/2999
Q55	The state of the s	subject to pre-service review. Check EIU policy, which	0, 10,2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4159	Affinity, per square centimeter		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. Not 1	12/1/2020	12/31/2999
		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. Not 1	12/1/2020	12/31/2999
		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. Not 5	5/15/2021	12/31/2999
		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. Not 5	5/15/2021	12/31/2999
		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. Not 1	12/1/2020	12/31/2999
		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. Not 1	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4400	Manual and his abia and a superior and a superior at an	(CPCP).	40/4/0000	40/04/0000
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 1	12/1/2020	12/31/2999
		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. Not 1	12/1/2020	12/31/2999
Q4 103	Woundex, bioskin, per square certimeter	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5	5/15/2021	12/31/2999
Q.110-1	rioncon, por oquaro continuotor	subject to pre-service review. Check EIU policy, which	0, 10,2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5	5/15/2021	12/31/2999
<u></u>		subject to pre-service review. Check EIU policy, which	0, .0,2021	12,01,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		1,51 61 ).		

Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
	Trofamative of Refusers, per square continuetor	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.4400	A december of the control of the con	(CPCP).	40/04/0000
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4170	Common non amount continue to	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q4170	Cygnus, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q+170	Cygnus, per square centimeter	subject to pre-service review. Check EIU policy, which	12/3/1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q+1/1	interryi, i mg	subject to pre-service review. Check EIU policy, which	12/3/1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
		(GFGF).	

Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q+111	interryi, i mg	subject to pre-service review. Check EIU policy, which	12/01/2000
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.11=0		(CPCP).	10/01/0000
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04477	Flavorensia fla 0.4 aa	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	40/04/0000
Q4177	Floweramnioflo, 0.1 cc		12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4177	Flowerompiefle, 0.1 as	(CPCP).	12/31/2999
Q41//	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04470	Flourerempionetals nor equate continuetar	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/21/2000
Q4178	Floweramniopatch, per square centimeter		12/31/2999
		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. Not 12/1/2020	12/31/2999
<u></u>	, ionoraliniopatori, por oqualio oontiiniotor	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		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. Not 12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.4400		(CPCP).	10/01/0000
Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4181	Amnio wound, per square centimeter	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q4101	Annilo wound, per square centimeter	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Q1101	7 mino mound, per equale continueter	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/2021	12/31/2999
		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. Not 5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.4400		(CPCP).	10/04/0000
Q4183	Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
Q+100	ourgigrant, per square centimeter	subject to pre-service review. Check EIU policy, which	12/3/1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
QT10 <del>1</del>	Ochesta of cellesta duo, per square certifiletel	subject to pre-service review. Check EIU policy, which	12/31/2333
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	

Q4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	/2020 12/31/2999
Q+10+	Concesta of Concesta ado, per equal continuetor	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	/2020 12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc		/2020 12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4186	Epifix, per square centimeter	· · · · · · · · · · · · · · · · · · ·	/2021 12/31/2999
		Medical Policy Criteria. Submit for Recommended	
		Clinical Review to avoid post-service review.	
Q4187	Epicord, per square centimeter		/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. Not 12/1/	/2020 12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.1100		(CPCP).	10000
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	/2020 12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4189	Artacent ac, 1 mg	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not   12/1/.	/2020 12/31/2999
Q4109	Anacent ac, 1 mg	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	/2020 12/31/2999
4	,	subject to pre-service review. Check EIU policy, which	,2020
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	/2020 12/31/2999
		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. Not 12/1/	/2020 12/31/2999
		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. Not 12/1/	/2020 12/31/2999
		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. Not 12/1/	/2020 12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	

Q4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	1/2020 12/31/2999	)
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	1/2020 12/31/2999	)
	· ·	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. Not 5/15/	5/2021 12/31/2999	9
		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. Not 5/15/	5/2021 12/31/2999	9
		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. Not 12/1/	1/2020 12/31/2999	9
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.440.4	N I I	(CPCP).	4 10000	
Q4194	Novachor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/	1/2020 12/31/2999	)
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4195	Duranty per aguare continuetor	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 5/15/	5/2021 12/31/2999	`
Q4 195	Puraply, per square centimeter	subject to pre-service review. Check EIU policy, which	5/2021 12/31/2998	9
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/	5/2021 12/31/2999	)
Q+100	r drupty, per equale continuetor	subject to pre-service review. Check EIU policy, which	0/2021	,
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/	5/2021 12/31/2999	)
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 5/15/	5/2021 12/31/2999	)
		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. Not 12/1/	1/2020 12/31/2999	<del>-</del>
		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. Not 12/1/	1/2020 12/31/2999	9
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	4/15/2022	12/31/2999
		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. Not	4/15/2022	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	5/15/2021	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.1001		(CPCP).	40440000	10/04/0000
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4000	V (0 5 - 1 ) 4	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	E/4E/0004	40/04/0000
Q4202	Keroxx (2.5g/cc), 1cc		5/15/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q4202	Neloxx (2.39/cc), 1cc	subject to pre-service review. Check EIU policy, which	3/13/2021	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q-1200	Bottila gido, por square continuetor	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q.1200	Solitia gido, por oqualo contillictor	subject to pre-service review. Check EIU policy, which	5, 10,2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
Q.20.	, map, por oqualo commission	subject to pre-service review. Check EIU policy, which	127172020	1.2,0.7,200
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		121211222
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4000	Fluid floor on fluid OF A or	(CPCP).	40/4/0000	40/04/0000
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
Q+200	140Valix, per square ceritificate	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
2 4 2 2 2		(CPCP).	40/4/0000	10/04/0000
Q4209	Surgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	6/30/2024
×7∠ 10	Avoidi graft of avoidi dualgraft, per square definitieter	subject to pre-service review. Check EIU policy, which	12/1/2020	0/00/2024
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	6/30/2024
		subject to pre-service review. Check EIU policy, which		3,00,202
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	2020 12/31/2999
Q4211	Annion bio of Axobiomembrane, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	12/31/2999
		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. Not 12/1/2	2020 12/31/2999
		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. Not 12/1/2	12/31/2999
		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. Not 12/1/2	12/31/2999
		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. Not 12/1/2	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2	12/31/2999
		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. Not 12/1/2	12/31/2999
		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. Not 12/1/2	12/31/2999
		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	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
Q.2.	BioWound Xplus, per square centimeter	subject to pre-service review. Check EIU policy, which	12/ 1/2020	12/01/2000
	Zioni dana 7, più di quali di donumi di di	is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
	BioWound Xplus, per square centimeter	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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4040		(CPCP).	10/1/0000	10/01/0000
Q4219	Surgigraft-dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4219	Surgigraft-dual, per square centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
Q4219	Surgigiant-dual, per square centimeter	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q 1220	Bolladoli 112 di Gardadini, poi oqualo dollamotol	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4004		(CPCP).	10/1/0000	10/01/0000
Q4221	Amniowrap2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	5/15/2021	12/31/2999
Q+ZZZ	i Togenamatiix, per square centimeter	subject to pre-service review. Check EIU policy, which	3/ 13/2021	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4222	Progenamatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	5/15/2021	12/31/2999
Q IZZZ	Tragation and a square contameter	subject to pre-service review. Check EIU policy, which	0/10/2021	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		1101 01 /.		

Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
QTZZT	Transaction to animotic pater (initio-p), per square certaineter	subject to pre-service review. Check EIU policy, which	0/1/2022	12/01/2000
		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. Not	8/1/2022	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	subject to pre-service review. Check EIU policy, which		1.2
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4225	Amniobind or dermabind tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
		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. Not	8/1/2022	12/31/2999
		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	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	centimeter	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	EIU: Procedure/service not reimbursed by the Plan. Not	10/1/2024	12/31/2999
	centimeter	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		7/1/2024	9/30/2024
	centimeter	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.1000		(CPCP).	10/1/0000	10/01/0000
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04000		(CPCP).	40/4/0000	40/04/0000
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04000	Company flourable american man 0.5 ac	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	40/4/0000	40/04/0000
Q4230	Cogenex flowable amnion, per 0.5 cc		12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
	γ - σ - σ - σ - σ - σ - σ - σ - σ - σ -	subject to pre-service review. Check EIU policy, which		1.2.3.2.2.3
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.1000		(CPCP).	10///0000	10/01/0000
Q4233	Surfactor or nudyn, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4000	0	(CPCP).	40/4/0000	40/04/0000
Q4233	Surfactor or nudyn, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
Q+Z0+	Accilerate, per square certameter	subject to pre-service review. Check EIU policy, which	12/1/2020	12/3 1/2333
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		1.2.3.3.2.3
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not 12/1/2020	12/31/2999
	subject to pre-service review. Check EIU policy, which	12/01/2000
	(CPCP).	
Cryo-cord, per square centimeter		12/31/2999
	subject to pre-service review. Check EIU policy, which	
	is one of our Clinical Payment and Coding Policy	
	(CPCP).	
Cryo-cord, per square centimeter		12/31/2999
Derm-maxx, per square centimeter		12/31/2999
Derm-maxx, per square centimeter		12/31/2999
Amnio-maxx or amnio-maxx lite, per square centimeter		12/31/2999
Amnio-maxx or amnio-maxx lite, per square centimeter		12/31/2999
Companies for tonical uses only man 0.5 as	(CPCP).	0 12/31/2999
Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2020	12/31/2999
Caracuta, for tanical use only, nor 0.5 cc	[(CPCP).	0 12/31/2999
Corecyte, for topical use only, per 0.5 cc		12/3 1/2999
Polycyte for tonical use only per 0.5 cc		12/31/2999
l olybyto, for topical accounty, per olo oc		12/01/2000
Polycyte, for topical use only, per 0.5 cc		12/31/2999
,, te, te, tep.ess. see e,, por elle es		12,5 2000
Amniocyte plus, per 0.5 cc		12/31/2999
		, .,,
	Cryo-cord, per square centimeter  Cryo-cord, per square centimeter  Derm-maxx, per square centimeter  Amnio-maxx or amnio-maxx lite, per square centimeter  Amnio-maxx or amnio-maxx lite, per square centimeter  Corecyte, for topical use only, per 0.5 cc  Corecyte, for topical use only, per 0.5 cc  Polycyte, for topical use only, per 0.5 cc  Polycyte, for topical use only, per 0.5 cc  Amniocyte plus, per 0.5 cc	Cryo-cord, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Cryo-cord, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Derm-maxx, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2022 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Derm-maxx, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2022 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Amnio-maxx or amnio-maxx lite, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/202 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Amnio-maxx or amnio-maxx lite, per square centimeter  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/202 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Corecyte, for topical use only, per 0.5 cc  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/202 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Corecyte, for topical use only, per 0.5 cc  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/202 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Polycyte, for topical use only, per 0.5 cc  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/202 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).  Polycyte, for topical use only, per 0.5 cc  EIU: Procedure/service not reimbursed by the Plan.

Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
~ ·- ·-	, annually to place, per old co	subject to pre-service review. Check EIU policy, which	, .,	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	3/31/2024
		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. Not	12/1/2020	3/31/2024
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.10.15		(CPCP).	101110000	10/04/0000
Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04046	Coretest or protest nor as	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	10/1/0000	12/31/2999
Q4246	Coretext or protext, per cc	subject to pre-service review. Check EIU policy, which	12/1/2020	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
Q-12-10	oblicion of protont, per ob	subject to pre-service review. Check EIU policy, which	12/1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4247	Amniotext patch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04040		(CPCP).	40/4/0000	40/04/0000
Q4248	Dermacyte amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	3/1/2021	12/31/2999
Q4248	Annilipiy, for topical use only, per square certifficier	subject to pre-service review. Check EIU policy, which	3/ 1/202 1	12/3/1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		[(UFUF).		

Q4249	Amniply, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	3/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	3/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	3/1/2021	12/31/2999
		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. Not	4/15/2022	12/31/2999
		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. Not	4/15/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04050	Vandaia nananyana asatimatan	(CPCP).	4/45/0000	40/04/0000
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	4/15/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	4/15/2022	12/31/2999
Q4232	vendaje, per square centimeter	subject to pre-service review. Check EIU policy, which	4/15/2022	12/31/2999
		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. Not	4/15/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		1-1-1-1-1-1-1
		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. Not	4/15/2022	12/31/2999
		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. Not	3/1/2021	12/31/2999
		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. Not	3/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4055		(CPCP).	0/4/000 1	10/01/0000
Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	3/1/2021	12/31/2999
		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. Not	3/1/2021	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
		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. Not	8/1/2022	12/31/2999
		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. Not	8/1/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.40=0		(CPCP).	0///0000	10/01/0000
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4050		(CPCP).	0/4/0000	40/04/0000
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	8/1/2022	12/31/2999
		subject to pre-service review. Check EIU policy, 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. Not	1/1/2023	12/31/2999
Q+200	Ociora dual layer of colora dual membrane, per square continuctor	subject to pre-service review. Check EIU policy, which	17 172020	12/01/2000
		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. Not	1/1/2023	12/31/2999
	,,	subject to pre-service review. Check EIU policy, which		1
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	1/1/2023	12/31/2999
		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. Not	1/1/2023	12/31/2999
		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. Not	1/1/2023	12/31/2999
		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. Not 1	1/1/2023	12/31/2999
		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. Not 1	1/1/2023	12/31/2999
		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. Not 1	1/1/2023	12/31/2999
		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. Not 1	1/1/2023	12/31/2999
		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. Not 1	1/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 1	1/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 1	1/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4005	N. C. O. C. A.	(CPCP).	2/4/2022	10/04/0000
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9	9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
04065	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9	2/4/2022	12/31/2999
Q4265	Neostini ti, per square centimeter	subject to pre-service review. Check EIU policy, which	9/1/2023	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9	9/1/2023	12/31/2999
Q 1200	11000till Hollistano, por oquaro contillictor	subject to pre-service review. Check EIU policy, which	J. 1/2020	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9	9/1/2023	12/31/2999
<u> </u>	Trees Monthario, por oquaro continuotor	subject to pre-service review. Check EIU policy, which		.2,01,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9	9/1/2023	12/31/2999
•.		subject to pre-service review. Check EIU policy, which		12,0 .,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
Q+201	recostini di, per square continuctor	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		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. Not 9/1/2023	12/31/2999
		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. Not 9/1/2023	12/31/2999
		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. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.40=4		(CPCP).	10/01/0000
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04074	Commission for many any and a material and a	(CPCP).	40/04/0000
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 9/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy (CPCP).	
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q4212	Esano a, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q4212	Loano a, per oquare centimeter	subject to pre-service review. Check EIU policy, which	12/3/1/2333
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q4213	Loano ada, per oquare centimeter	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
		I(CLCL).	

Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q.2.0		subject to pre-service review. Check EIU policy, which	12/6 1/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
		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. Not 12/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	12/2/22
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.4075		(CPCP).	40/04/0000
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4276	Onion management and the char	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q4276	Orion, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
Q4276	Orion, per square centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	12/31/2999
Q4270	Onon, per square centimeter	subject to pre-service review. Check EIU policy, which	12/3 1/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	6/30/2024
Q 1277	Troundplace membrane or or grant, per oqual or continuous	subject to pre-service review. Check EIU policy, which	6/86/2621
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4277	Woundplus membrane or e-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 12/1/2023	6/30/2024
		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. Not 12/1/2023	12/31/2999
		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. Not 12/1/2023	12/31/2999
		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. Not 7/1/2024	12/31/2999
		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. Not 7	7/1/2024	12/31/2999
Q.2.0	Tomage as, por equal of committee	subject to pre-service review. Check EIU policy, which	.,.,	12,01,200
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4279	Vendaje ac, per square centimeter		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. Not	12/1/2023	12/31/2999
		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. Not	12/1/2023	12/31/2999
		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. Not	12/1/2023	12/31/2999
		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		12/1/2023	12/31/2999
		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		12/1/2023	12/31/2999
		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		12/1/2023	12/31/2999
		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		8/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.400.4		Clinical Review to avoid post-service review.	101110000	10/01/0000
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 1	12/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.400.4	Downship dad a consequence of the state	(CPCP).	40/4/0000	40/04/0000
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2023	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 1	10/1/2023	12/31/2999
Q4200	Nudyn di or nudyn di mesn, per square centimeter		10/1/2023	12/3 1/2999
		subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy		
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 1	10/1/2022	12/31/2999
Q4200	rivudyn di di niddyn di mesn, per square centimeter	subject to pre-service review. Check EIU policy, which	10/1/2023	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		· · · · · · · · · · · · · · · · · · ·		
		(CPCP).		

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

Q4290	Membrane wrap-hydro, per square centimeter	MP Criteria: Procedure/service reviewed against	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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.400.4		(CPCP).	7///000/	10/01/0000
Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		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
Q4291	Lamenas XI, per square centimeter	Medical Policy Criteria. Submit for Recommended	3/13/2024	0/30/2024
		Clinical Review to avoid post-service review.		
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q+202	Lamonas, por square continuetor	subject to pre-service review. Check EIU policy, which	77172024	12/3 1/2333
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4292	Lamellas, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024	6/30/2024
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.1000		(CPCP).	7///000/	10/01/0000
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4293	Acesso dl, per square centimeter	(CPCP). MP Criteria: Procedure/service reviewed against	3/15/2024	6/30/2024
Q4293	Acesso di, per square centimeter	Medical Policy Criteria. Submit for Recommended	3/13/2024	0/30/2024
		Clinical Review to avoid post-service review.		
Q4294	Amnio quad-core, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q+20+	Annilo quad-core, per square continueter	subject to pre-service review. Check EIU policy, which	77172024	12/3 1/2333
		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. Not	7/1/2024	12/31/2999
	, , , ,	subject to pre-service review. Check EIU policy, 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		
		Clinical Review to avoid post-service review.		

Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q4233	Annio di-core anniodo, per square centimeter	subject to pre-service review. Check EIU policy, which	77172024	12/3 1/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, 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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4007		(CPCP).	0/45/0004	0/00/0004
Q4297	Emerge matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024	6/30/2024
		Medical Policy Criteria. Submit for Recommended		
Q4298	Ampieere pre per eguere contimeter	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not	7/4/2024	12/31/2999
Q4290	Amnicore pro, per square centimeter	subject to pre-service review. Check EIU policy, which	7/1/2024	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q+200	Annibore pro, per square certaineter	subject to pre-service review. Check EIU policy, which	77172024	12/3 1/2333
		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
Q 1200	7 miniotio pro, por oquare continuotor	Medical Policy Criteria. Submit for Recommended	5/ 10/2024	5,00,2024
		Clinical Review to avoid post-service review.		
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
<u> </u>	, manages pro spor oquare commission	subject to pre-service review. Check EIU policy, which		.2,01,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		<sub>I(</sub> Oi Oi <i>)</i> .		

Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q.200	, annuació pro , por equare contamicos	subject to pre-service review. Check EIU policy, which	., ., _ 0	12/01/2000
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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		
0.4000		Clinical Review to avoid post-service review.	7/1/0001	10/01/0000
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4302	Complete and nor aguera continuetor	(CPCP).	7/4/2024	12/21/2000
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which	7/1/2024	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4302	Complete aca, per square centimeter		3/15/2024	6/30/2024
Q4302	Complete aca, per square centimeter	Medical Policy Criteria. Submit for Recommended	3/13/2024	0/30/2024
		Clinical Review to avoid post-service review.		
Q4303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q 1000	Samplete da, per equal e continueter	subject to pre-service review. Check EIU policy, which	,, i, <u>L</u> UL	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
~ 1000	Sampleto da, por oqualo continuotor	subject to pre-service review. Check EIU policy, which	., 1/2027	12,01,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
		Not of j.		

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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		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. Not 4/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.1000		(CPCP).	10/04/0000
Q4308	Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
0.1000		(CPCP).	10/04/0000
Q4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04200	Via matrix, nor aguara continuator	(CPCP).	12/21/2000
Q4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
04240	Draganta nor 100 mg	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 4/1/2024	10/21/2000
Q4310	Procenta, per 100 mg		12/31/2999
		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. Not	4/1/2024	12/31/2999
	,, ,,	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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, 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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, 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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.404.5		(CPCP).	7///000/	10/01/0000
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
04045	Daniel Bulliani de Carante de Car	(CPCP).	7/4/0004	40/04/0000
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4040		(CPCP).	7/4/005 1	10/04/0000
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4000	Della mark management in the second	(CPCP).	7/4/0004	40/04/0000
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy (CPCP).		
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q4320	Pellogrant, per square centimeter	subject to pre-service review. Check EIU policy, which	77172024	12/3 1/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q 1021	rtonograft, por oquaro continuctor	subject to pre-service review. Check EIU policy, which	77 17202 1	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		12,5 1,255
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
	- 3. 5g. s, p.s. 5 quan 5 55 (Milliotte)	subject to pre-service review. Check EIU policy, which		12,5 1,255
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		

Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2024	12/31/2999
Q.1022	January per equals commission	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2024	12/31/2999
		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. Not 7/1/2024	12/31/2999
		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. Not 7/1/2024	12/31/2999
		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. Not 7/1/2024	12/31/2999
		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. Not 7/1/2024	12/31/2999
		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. Not 7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which	
		is one of our Clinical Payment and Coding Policy	
Q4326	Maundalus, nor aquare continutor	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2024	12/31/2999
Q4320	Woundplus, per square centimeter	exhibite the proportion review. Check FUL relieve which	12/31/2999
		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. Not 7/1/2024	12/31/2999
Q4320	Woundplus, per square centimeter	subject to pre-service review. Check EIU policy, which	12/31/2999
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2024	12/31/2999
Q.102.	2 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	subject to pre-service review. Check EIU policy, which	12/01/2000
		is one of our Clinical Payment and Coding Policy	
		(CPCP).	
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 7/1/2024	12/31/2999
	,	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. Not 7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
Q4320	imost, per square certificater	subject to pre-service review. Check EIU policy, which	77 172024	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		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. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
0.4004		(CPCP).	7/4/0004	10/01/0000
Q4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
Q4332	Axolotl dualgraft, per square centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q4332	Axoloti dualgrait, per square certumeter	subject to pre-service review. Check EIU policy, which	77 172024	12/31/2999
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
Q+002	Two oth dualigrant, por oquare continued	subject to pre-service review. Check EIU policy, which	77 172024	12/01/2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not	7/1/2024	12/31/2999
		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 units	MP Criteria: Procedure/service reviewed against	4/15/2020	12/31/2999
		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-eqrn (cimerli), biosimilar, 0.1 mg	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.		
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		
		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		
		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
l		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	Non Covered: Procedure/service not covered by the	4/1/2005	12/31/2999
	THROUGH DME, CONCENTRATED FORM, PER MG	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	Paramedic intercept, non-hospital-based als service (non-voluntary), non-	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
	member for monitoring purposes; per month	Plan. Not subject to pre-service review.		
S0596	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR	MP Criteria: Procedure/service reviewed against	4/1/2012	12/31/2999
		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
	· ·	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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, 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		
		Clinical Review to avoid post-service review.		
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	autologous, harvesting, transplantation, and related complications; including:	Medical Policy Criteria. Submit for Recommended		
	pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies,	Clinical Review to avoid post-service review.		
	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 on	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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 tracheal	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	occlusion, procedure performed in utero	Medical Policy Criteria. Submit for Recommended	. 67 172020	1270 172000
	occident, procedure periorities in state	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
		Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
S2402	Repair, congenital cystic adenomatoid malformation in the fetus, procedure	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	performed in utero	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
	periorina in alore	Clinical Review to avoid post-service review.		
S2403	Repair, extralobar pulmonary sequestration 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.		
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 utero	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2409	Repair, congenital malformation of fetus, procedure performed in utero, not	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	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 syndrome	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		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 residing in a	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	nursing facility	Plan. Not subject to pre-service review.		
S3650	Saliva test, hormone level; during menopause		12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/1/2020	12/31/2999
		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. Not	12/15/2014	12/31/2999
		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. Not	12/15/2014	12/31/2999
		subject to pre-service review. Check EIU policy, which		1
		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
0.400.4		Plan. Not subject to pre-service review.	4/4/4050	10/01/0000
S4031	Sperm procurement and cryopreservation services; subsequent visit	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04040	Manifestration and observe of amount of an above of a above of a a	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
34990	Nicotine patches, legend	Plan. Not subject to pre-service review.	1/1/1950	12/3 1/2999
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.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.2.0.1.200
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, per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		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
S5109	Llama agra training to hama agra client, nor aggainn	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
55109	Home care training to home care client, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5110	Home care training, family; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
55110	Thome care training, family, per 15 minutes	Plan. Not subject to pre-service review.	17 17 1950	12/3 1/2999
S5111	Home care training, family; per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	The same daming, ranning, per essentin	Plan. Not subject to pre-service review.	., .,	12/01/2000
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	J. 7,1	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
0=100		Plan. Not subject to pre-service review.	4444055	10/01/000
S5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
S5130	Homomokor camilac, non 15 minutes	Plan. Not subject to pre-service review.	1/1/1050	12/21/2000
55130	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 Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5135	Companion care, adult (e. G. ladl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
S5136	Companion care, adult (e. G. ladl/adl); per diem	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5162	Emergency response system; purchase only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5165	Home modifications; per service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5199	Personal care item, nos, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not	11/1/2016	12/31/2999
		subject to pre-service review. Check EIU policy, which	, .,	1.2,0.1,2000
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not	11/1/2016	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non Covered: Procedure/service not covered by the	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
		Plan. Not subject to pre-service review.		
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS;	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE	Medical Policy Criteria. Submit for Recommended		
	PATIENT	Clinical Review to avoid post-service review.		
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	EIU: Procedure/service not reimbursed by the Plan. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
S8948	Application of a modality (requiring constant provider attendance) to one or more		9/24/2012	12/31/2999
	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. Not	9/1/2020	12/31/2999
		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. Not	9/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00000		(CPCP).	4/4/0004	10/04/0000
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle		4/1/2024	12/31/2999
	rehabilitation device	Medical Policy Criteria. Submit for Recommended		
00055	Duran and the sum of t	Clinical Review to avoid post-service review.	44/4/0040	40/04/0000
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		
COOFG	Comp atimulation nor diam	Clinical Review to avoid post-service review.	10/1/0000	12/21/2002
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
00050	O	(CPCP).	40/4/0000	40/04/0000
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan. Not	12/1/2020	12/31/2999
		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. Not	12/15/2014	12/31/2999
		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. Not	12/15/2014	12/31/2999
		subject to pre-service review. Check EIU policy, which		
		is one of our Clinical Payment and Coding Policy		
		(CPCP).		
S9117	Back school, per visit	MP Criteria: Procedure/service reviewed against	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; per	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	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 session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		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 session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		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
		Plan. Not subject to pre-service review.		
S9454	Stress 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.		
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
S9558	Home injectable therapy; growth hormone, including administrative services,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	professional pharmacy services, care coordination, and all necessary supplies	Medical Policy Criteria. Submit for Recommended		
	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
	including administrative services, professional pharmacy services, care	Medical Policy Criteria. Submit for Recommended		
	coordination, and all necessary supplies and equipment (drugs and nursing visits	Clinical Review to avoid post-service review.		
	coded separately), per diem			
S9900	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	FOR THE PURPOSE OF HEALING, PER DIEM	Plan. Not subject to pre-service review.		
S9960		MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	(fixed wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9961	Ambulance service, conventional air service, nonemergency transport, one way	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	(rotary wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S9970	Health club membership, annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9976	Lodging, per diem, not otherwise classified	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
39970	Loughig, per diem, not otherwise classified	1	1/1/1950	12/31/2999
S9977	Meals, per diem, not otherwise specified	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
39911	ividais, per diem, not otherwise specified	· · · · · · · · · · · · · · · · · · ·	1/1/1950	12/31/2999
S9981	Medical records copying fee, administrative	Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
39901	ivieuicai records copying ree, administrative	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9982	Medical records copying fee, per page	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
3990Z	Interior records copyring ree, per page	Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
S9986	Not medically necessary service (patient is aware that service not medically	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	necessary)	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S9988	Services provided as part of a phase i clinical trial	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	Solviose provided de part of a prideo i diffical didi	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S9989	Services provided outside of the united states of america (list in addition to	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	code(s) for services(s))	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S9990	Services provided as part of a phase ii clinical trial	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00000	Provided as part of a phase in similar than	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S9991	Services provided as part of a phase iii clinical trial	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00001	Portion provided as part of a phase in similar than	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S9992	Transportation costs to and from trial location and local transportation costs (e.	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00002	G. , fares for taxicab or bus) for clinical trial participant and one	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
	caregiver/companion	Than. The subject to pro convice fortion.		
S9994	Lodging costs (e. G. , hotel charges) for clinical trial participant and one	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	caregiver/companion	Plan. Not subject to pre-service review.	., ., ., .,	12/01/2000
S9996	Meals for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	The sale is a similar parasipant and one caregine, companies.	Plan. Not subject to pre-service review.	., .,	12/0 //2000
S9999	Sales tax	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2025	Deluxe frame	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
V2219	Bifocal seg width over 28mm	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2600	Hand held low vision aids and other nonspectacle mounted aids	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	'	Plan. Not subject to pre-service review.		
V2610	Single lens spectacle mounted low vision aids	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2615	Telescopic and other compound lens system, including distance vision	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	telescopic, near vision telescopes and compound microscopic lens system	Plan. Not subject to pre-service review.		
V2627	Scleral cover shell	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.		
V2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
V2715	Prism, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
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.		
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	way	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
A0380	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 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
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	jurisdictions where defibrillation cannot be performed by BLS ambulances)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This 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
71000-4		Medical Policy Criteria. Submit for Recommended		1.2.2.1.2.2.2
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
\0396	ALS specialized service disposable supplies; esophageal intubation	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	, and opposition and anoposition outperiors, soop integral initial and in	Medical Policy Criteria. Submit for Recommended	., ., _ 0_0	1270 172000
		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
-10000	ALO TOURNO disposable supplies	Medical Policy Criteria. Submit for Recommended	17 172020	12/01/2000
		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
A0420	Ambulance waiting time (ALS of BLS), one half (1/2) hour increments	Medical Policy Criteria. Submit for Recommended	1/1/2025	12/31/2999
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
AU422	Affibulance (ALS of BLS) oxygen and oxygen supplies, life sustaining situation		1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This code		
10101	Fitter and the standard amount (ALC and DLC) are size (five day and an additional)	is managed by Alacura.	4/4/0005	40/04/0000
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged);	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(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		
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
A0426	Ambulance service, advanced life support, non-emergency transport, Level 1	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(ALS1)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		
A0427	· · · · · · · · · · · · · · · · · · ·	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.		
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-Emergency)	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.		
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	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.		

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 party	Medical Policy Criteria. Submit for Recommended		
	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.		
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.		
S9961	Ambulance service, conventional air service, nonemergency transport, one way		1/1/2025	12/31/2999
	(rotary wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This code		
		is managed by Alacura.		

CPT copyright 2024 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

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

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

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

Alacura Medical Transportation Management, LLC. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide utilization management services for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Carelon Medical Benefits Management.