BlueCross BlueShield of New Mexico

2024 Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered Procedure Code List - Administrative Services Only (ASO) Accounts
Effective 1/1/2024
(Updated June 2024)

This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes related to services/categories for which prior authorization may be required as of January 1, 2024 unless otherwise indicated through Blue Cross and Blue Shield of New Mexico managed for one or more of our networks: - PPO℠ -Blue Preferred EPO -Blue Preferred Plus -HMO	Utilization Management Process This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	Anesthesia For Manipulation Of The Spine Or For Closed Procedures On The Cervical Thoracic Or Lumbar Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
00797	Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure For Morbid Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
07957	Weight Loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
11200	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Up To And Including 15 Lesions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

11201	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Each Additional 10 Lesions Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
11920	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.0 Sq Cm Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11921	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.1 To 20.0 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11922	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; Each Additional 20.0 Sq Cm Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against 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 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11952	Subcutaneous Injection Of Filling Material (Eg Collagen); 5.1 To 10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11954	Subcutaneous Injection Of Filling Material (Eg Collagen); Over 10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11960	Insertion Of Tissue Expander(S) For Other Than Breast Including Subsequent Expansion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11970	Replacement Of Tissue Expander With Permanent Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
11980	Subcutaneous Hormone Pellet Implantation (Implantation Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15271	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15272	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15273	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

15274	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15275	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15276	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15277	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15278	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15758	Free Fascial Flap With Microvascular Anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15769	Grafting Of Autologous Soft Tissue Other Harvested By Direct Excision (Eg Fat Dermis Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15771	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; 50 Cc Or Less Injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15772	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; Each Additional 50 Cc Injectate Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15775	Punch Graft For Hair Transplant; 1 To 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

15776	Punch Graft For Hair Transplant; More Than 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15780	Dermabrasion; Total Face (Eg For Acne Scarring Fine Wrinkling Rhytids General Keratosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15781	Dermabrasion; Segmental Face	MP Criteria: Procedure/service reviewed against 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 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 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 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 For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15788	Chemical Peel Facial; Epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15789	Chemical Peel Facial; Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15792	Chemical Peel Nonfacial; Epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15793	Chemical Peel Nonfacial; Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15820	Blepharoplasty Lower Eyelid;	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15822	Blepharoplasty Upper Eyelid;	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

15824	Rhytidectomy; Forehead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
15825	Rhytidectomy; Neck With Platysmal Tightening (Platysmal Flap P-Flap)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15826	Rhytidectomy; Glabellar Frown Lines	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
15828	Rhytidectomy; Cheek Chin And Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15829	Rhytidectomy; Superficial Musculoaponeurotic System (Smas) Flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15830	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Abdomen Infraumbilical Panniculectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15832	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15833	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15834	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15835	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Buttock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15836	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15837	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Forearm Or Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15838	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Submental Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15839	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Other Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

15847	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy) Abdomen (Eg Abdominoplasty) (Includes Umbilical Transposition And Fascial Plication) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15876	Suction Assisted Lipectomy; Head And Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15877	Suction Assisted Lipectomy; Trunk	MP Criteria: Procedure/service reviewed against 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 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
15999	Unlisted Procedure Excision Pressure Ulcer	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
17106	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); Less Than 10 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
17107	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); 10.0 To 50.0 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
17108	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); Over 50.0 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
17340	Cryotherapy (Co2 Slush Liquid N2) For Acne	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
17360	Chemical Exfoliation For Acne (Eg Acne Paste Acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
17380	Electrolysis Epilation Each 30 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
17999	Unlisted Procedure Skin Mucous Membrane And Subcutaneous Tissue	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
19105	Ablation Cryosurgical Of Fibroadenoma Including Ultrasound Guidance Each Fibroadenoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19300	Mastectomy For Gynecomastia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

19303	Mastectomy Simple Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19316	Mastopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024	Retire effective 04/14/2024
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
19325	Breast Augmentation With Implant	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19330	Removal Of Ruptured Breast Implant Including Implant Contents (Eg Saline Silicone Gel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19340	Insertion Of Breast Implant On Same Day Of Mastectomy (Ie Immediate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19342	Insertion Or Replacement Of Breast Implant On Separate Day From Mastectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19350	Nipple/Areola Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19355	Correction Of Inverted Nipples	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19357	Tissue Expander Placement In Breast Reconstruction Including Subsequent Expansion(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19370	Revision Of Peri-Implant Capsule Breast Including Capsulotomy Capsulorrhaphy And/Or Partial Capsulectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
19371	Peri-Implant Capsulectomy Breast Complete Including Removal Of All Intracapsular Contents	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

19499	Unlisted Procedure Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
20527	Injection Enzyme (Eg Collagenase) Palmar Fascial Cord (Ie Dupuytren'S Contracture)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
20560	Needle Insertion(S) Without Injection(S); 1 Or 2 Muscle(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
20561	Needle Insertion(S) Without Injection(S); 3 Or More Muscles	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed; Cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
20985	Computer-Assisted Surgical Navigational Procedure For Musculoskeletal Procedures Image-Less (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
20999	Unlisted Procedure Musculoskeletal System General	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21073	Manipulation Of Temporomandibular Joint(S) (Tmj) Therapeutic Requiring An Anesthesia Service (Ie General Or Monitored Anesthesia Care)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
21089	Unlisted Maxillofacial Prosthetic Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21120	Genioplasty; Augmentation (Autograft Allograft Prosthetic Material)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
21121	Genioplasty; Sliding Osteotomy Single Piece	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
21122	Genioplasty; Sliding Osteotomies 2 Or More Osteotomies (Eg Wedge Excision Or Bone Wedge Reversal For Asymmetrical Chin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

21123	Genioplasty; Sliding Augmentation With Interpositional Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
21125	Augmentation Mandibular Body Or Angle; Prosthetic Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024	Retire effective 04/14/2024
21127	Augmentation Mandibular Body Or Angle; With Bone Graft Onlay Or Interpositional (Includes Obtaining Autograft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/14/2024	Retire effective 04/14/2024
21145	Reconstruction Midface Lefort I; Single Piece Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
21146	Reconstruction Midface Lefort I; 2 Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Unilateral Alveolar Cleft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
21147	Reconstruction Midface Lefort I; 3 Or More Pieces Segment Movement In Any Direction Requiring Bone Grafts (Includes Obtaining Autografts) (Eg Ungrafted Bilateral Alveolar Cleft Or Multiple Osteotomies)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
21150	Reconstruction Midface Lefort Ii; Anterior Intrusion (Eg Treacher-Collins Syndrome)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
21151	Reconstruction Midface Lefort Ii; Any Direction Requiring Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
21154	Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

21155	Reconstruction Midface Lefort Iii (Extracranial) Any Type Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21159	Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); Without Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21160	Reconstruction Midface Lefort Iii (Extra And Intracranial) With Forehead Advancement (Eg Mono Bloc) Requiring Bone Grafts (Includes Obtaining Autografts); With Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21188	Reconstruction Midface Osteotomies (Other Than Lefort Type) And Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21206	Osteotomy Maxilla Segmental (Eg Wassmund Or Schuchard)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21208	Osteoplasty Facial Bones; Augmentation (Autograft Allograft Or Prosthetic Implant)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21209	Osteoplasty Facial Bones; Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
21244	Reconstruction Of Mandible Extraoral With Transosteal Bone Plate (Eg Mandibular Staple Bone Plate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	–	Add effective 04/01/2024
21245	Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	–	Add effective 04/01/2024
21246	Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	–	Add effective 04/01/2024
21248	Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Partial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

21249	Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
21299	Unlisted Craniofacial And Maxillofacial Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21499	Unlisted Musculoskeletal Procedure Head	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
21685	Hyoid Myotomy And Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
21899	Unlisted Procedure Neck Or Thorax	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
22505	Manipulation Of Spine Requiring Anesthesia Any Region	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
22526	Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22527	Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or More Additional Levels (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22586	Arthrodesis Pre-Sacral Interbody Technique Including Disc Space Preparation Discectomy With Posterior Instrumentation With Image Guidance Includes Bone Graft When Performed L5-S1 Interspace	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22836	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
22836	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22837	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
22837	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22838	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024

22838	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
22867	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22869	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22870	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
22899	Unlisted Procedure Spine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
22999	Unlisted Procedure Abdomen Musculoskeletal System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
23929	Unlisted Procedure Shoulder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
24300	Manipulation Elbow Under Anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
24999	Unlisted Procedure Humerus Or Elbow	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
25259	Manipulation Wrist Under Anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
25999	Unlisted Procedure Forearm Or Wrist	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
26340	Manipulation Finger Joint Under Anesthesia Each Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

26341	Manipulation Palmar Fascial Cord (Ie Dupuytren'S Cord) Post Enzyme Injection (Eg Collagenase) Single Cord	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
26989	Unlisted Procedure Hands Or Fingers	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27275	Manipulation Hip Joint Requiring General Anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
27278	Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
27278	Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
27299	Unlisted Procedure Pelvis Or Hip Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27599	Unlisted Procedure Femur Or Knee	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
27703	Arthroplasty Ankle; Revision Total Ankle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
27860	Manipulation Of Ankle Under General Anesthesia (Includes Application Of Traction Or Other Fixation Apparatus)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
27899	Unlisted Procedure Leg Or Ankle	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
28890	Extracorporeal Shock Wave High Energy Performed By A Physician Or Other Qualified Health Care Professional Requiring Anesthesia Other Than Local Including Ultrasound Guidance Involving The Plantar Fascia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
28899	Unlisted Procedure Foot Or Toes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
29440	Adding Walker To Previously Applied Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
29799	Unlisted Procedure Casting Or Strapping	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
29866	Arthroscopy Knee Surgical; Osteochondral Autograft(S) (Eg Mosaicplasty) (Includes Harvesting Of The Autograft[S])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

29867	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg Mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
29914	Arthroscopy Hip Surgical; With Femoroplasty (Ie Treatment Of Cam Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
29915	Arthroscopy Hip Surgical; With Acetabuloplasty (Ie Treatment Of Pincer Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
29916	Arthroscopy Hip Surgical; With Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
29999	Unlisted Procedure Arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
30468	Repair Of Nasal Valve Collapse With Subcutaneous/Submucosal Lateral Wall Implant(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
30469	Repair Of Nasal Valve Collapse With Low Energy Temperature-Controlled (Ie Radiofrequency) Subcutaneous/Submucosal Remodeling	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
30999	Unlisted Procedure Nose	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
31242	Nasal/Sinus Endoscopy Surgical; With Destruction By Radiofrequency Ablation Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
31242	Nasal/Sinus Endoscopy Surgical; With Destruction By Radiofrequency Ablation Posterior Nasal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
31243	Nasal/Sinus Endoscopy Surgical; With Destruction By Cryoablation Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
31243	Nasal/Sinus Endoscopy Surgical; With Destruction By Cryoablation Posterior Nasal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024

31299	Unlisted Procedure Accessory Sinuses	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
31599	Unlisted Procedure Larynx	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
31899	Unlisted Procedure Trachea Bronchi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	_
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.	_	_	_
32999	Unlisted Procedure Lungs And Pleura	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
33274	Transcatheter Insertion Or Replacement Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33275	Transcatheter Removal Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

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	–	Add effective 05/15/2024
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]) Including Vessel Catheterization All Imaging Guidance And Pulse Generator Initial Analysis With Diagnostic Mode Activation When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	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	Add effective 02/15/2024 Retire effective 05/14/2024
33279	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024
33279	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	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	Add effective 02/15/2024 Retire effective 05/14/2024
33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024
33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024

33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33285	Insertion Subcutaneous Cardiac Rhythm Monitor Including Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
33288	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33288	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	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	Add effective 02/15/2024 Retire effective 05/14/2024
33289	Transcatheter Implantation Of Wireless Pulmonary Artery Pressure Sensor For Long-Term Hemodynamic Monitoring Including Deployment And Calibration Of The Sensor Right Heart Catheterization Selective Pulmonary Catheterization Radiological Supervision And Interpretation And Pulmonary Artery Angiography When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33418	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33419	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Additional Prosthesis(Es) During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33542	Myocardial Resection (Eg Ventricular Aneurysmectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
33999	Unlisted Procedure Cardiac Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

36299	Unlisted Procedure Vascular Injection	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
36465	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Single Incompetent Extremity Truncal Vein (Eg Great Saphenous Vein Accessory Saphenous Vein)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
36466	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Multiple Incompetent Truncal Veins (Eg Great Saphenous Vein Accessory Saphenous Vein) Same Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
36468	Injection(S) Of Sclerosant For Spider Veins (Telangiectasia) Limb Or Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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).	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_

36479	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Laser; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
36482	Endovenous Ablation Therapy Of Incompetent Vein Extremity By Transcatheter Delivery Of A Chemical Adhesive (Eg Cyanoacrylate) Remote From The Access Site Inclusive Of All Imaging Guidance And Monitoring Percutaneous; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
36516	Therapeutic Apheresis; With Extracorporeal Immunoadsorption Selective Adsorption Or Selective Filtration And Plasma Reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
36522	Photopheresis Extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
36836	Percutaneous Arteriovenous Fistula Creation Upper Extremity Single Access Of Both The Peripheral Artery And Peripheral Vein Including Fistula Maturation Procedures (Eg Transluminal Balloon Angioplasty Coil Embolization) When Performed Including All Vascular Access Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
36837	Percutaneous Arteriovenous Fistula Creation Upper Extremity Separate Access Sites Of The Peripheral Artery And Peripheral Vein Including Fistula Maturation Procedures (Eg Transluminal Balloon Angioplasty Coil Embolization) When Performed Including All Vascular Access Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
37215	Transcatheter Placement Of Intravascular Stent(S) Cervical Carotid Artery Open Or Percutaneous Including Angioplasty When Performed And Radiological Supervision And Interpretation; With Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

37216	Transcatheter Placement Of Intravascular Stent(S) Cervical Carotid Artery Open Or Percutaneous Including Angioplasty When Performed And Radiological Supervision And Interpretation; Without Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37217	Transcatheter Placement Of Intravascular Stent(S) Intrathoracic Common Carotid Artery Or Innominate Artery By Retrograde Treatment Open Ipsilateral Cervical Carotid Artery Exposure Including Angioplasty When Performed And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37218	Transcatheter Placement Of Intravascular Stent(S) Intrathoracic Common Carotid Artery Or Innominate Artery Open Or Percutaneous Antegrade Approach Including Angioplasty When Performed And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37241	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; Venous Other Than Hemorrhage (Eg Congenital Or Acquired Venous Malformations Venous And Capillary Hemangiomas Varices Varicoceles)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37242	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; Arterial Other Than Hemorrhage Or Tumor (Eg Congenital Or Acquired Arterial Malformations Arteriovenous Malformations Arteriovenous Fistulas Aneurysms Pseudoaneurysms)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37243	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; For Tumors Organ Ischemia Or Infarction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37244	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; For Arterial Or Venous Hemorrhage Or Lymphatic Extravasation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37500	Vascular Endoscopy Surgical With Ligation Of Perforator Veins Subfascial (Seps)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37501	Unlisted Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

37700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction Or Distal Interruptions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37718	Ligation Division And Stripping Short Saphenous Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37722	Ligation Division And Stripping Long (Greater) Saphenous Veins From Saphenofemoral Junction To Knee Or Below	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins With Radical Excision Of Ulcer And Skin Graft And/Or Interruption Of Communicating Veins Of Lower Leg With Excision Of Deep Fascia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37760	Ligation Of Perforator Veins Subfascial Radical (Linton Type) Including Skin Graft When Performed Open 1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37761	Ligation Of Perforator Vein(S) Subfascial Open Including Ultrasound Guidance When Performed 1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37765	Stab Phlebectomy Of Varicose Veins 1 Extremity; 10-20 Stab Incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37766	Stab Phlebectomy Of Varicose Veins 1 Extremity; More Than 20 Incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37780	Ligation And Division Of Short Saphenous Vein At Saphenopopliteal Junction (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37785	Ligation Division And/Or Excision Of Varicose Vein Cluster(S) 1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
37799	Unlisted Procedure Vascular Surgery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
38129	Unlisted Laparoscopy Procedure Spleen	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
38204	Management Of Recipient Hematopoietic Progenitor Cell Donor Search And Cell Acquisition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38205	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38206	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

38207	Transplant Preparation Of Hematopoietic Progenitor Cells; Cryopreservation And Storage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38208	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest Without Washing Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38209	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest With Washing Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38210	Transplant Preparation Of Hematopoietic Progenitor Cells; Specific Cell Depletion Within Harvest T-Cell Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38211	Transplant Preparation Of Hematopoietic Progenitor Cells; Tumor Cell Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38212	Transplant Preparation Of Hematopoietic Progenitor Cells; Red Blood Cell Removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38213	Transplant Preparation Of Hematopoietic Progenitor Cells; Platelet Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38214	Transplant Preparation Of Hematopoietic Progenitor Cells; Plasma (Volume) Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38215	Transplant Preparation Of Hematopoietic Progenitor Cells; Cell Concentration In Plasma Mononuclear Or Buffy Coat Layer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38230	Bone Marrow Harvesting For Transplantation; Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
38232	Bone Marrow Harvesting For Transplantation; Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38240	Hematopoietic Progenitor Cell (Hpc); Allogeneic Transplantation Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38241	Hematopoietic Progenitor Cell (Hpc); Autologous Transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
38242	Allogeneic Lymphocyte Infusions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

38243	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38308	Lymphangiotomy Or Other Operations On Lymphatic Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
38589	Unlisted Laparoscopy Procedure Lymphatic System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
38999	Unlisted Procedure Hemic Or Lymphatic System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
39499	Unlisted Procedure Mediastinum	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
39599	Unlisted Procedure Diaphragm	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
40799	Unlisted Procedure Lips	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
40899	Unlisted Procedure Vestibule Of Mouth	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
41530	Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	3/31/2024	Retire effective 03/31/2024
41530	Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
41599	Unlisted Procedure Tongue Floor Of Mouth	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
41820	Gingivectomy Excision Gingiva Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41821	Operculectomy Excision Pericoronal Tissues	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41822	Excision Of Fibrous Tuberosities Dentoalveolar Structures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41823	Excision Of Osseous Tuberosities Dentoalveolar Structures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41828	Excision Of Hyperplastic Alveolar Mucosa Each Quadrant (Specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41830	Alveolectomy Including Curettage Of Osteitis Or Sequestrectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41870	Periodontal Mucosal Grafting	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41872	Gingivoplasty Each Quadrant (Specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41874	Alveoloplasty Each Quadrant (Specify)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
41899	Unlisted Procedure Dentoalveolar Structures	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

42140	Uvulectomy Excision Of Uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
42145	Palatopharyngoplasty (Eg Uvulopalatopharyngoplasty Uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
42299	Unlisted Procedure Palate Uvula	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
42699	Unlisted Procedure Salivary Glands Or Ducts	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
42950	Pharyngoplasty (Plastic Or Reconstructive Operation On Pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
42999	Unlisted Procedure Pharynx Adenoids Or Tonsils	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43206	Esophagoscopy Flexible Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
43236	Esophagogastroduodenoscopy Flexible Transoral; With Directed Submucosal Injection(S) Any Substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43252	Esophagogastroduodenoscopy Flexible Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
43284	Laparoscopy Surgical Esophageal Sphincter Augmentation Procedure Placement Of Sphincter Augmentation Device (Ie Magnetic Band) Including Cruroplasty When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43289	Unlisted Laparoscopy Procedure Esophagus	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43290	Esophagogastroduodenoscopy Flexible Transoral; With Deployment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
43291	Esophagogastroduodenoscopy Flexible Transoral; With Removal Of Intragastric Bariatric Balloon(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
43499	Unlisted Procedure Esophagus	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43632	Gastrectomy Partial Distal; With Gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

43633	Gastrectomy Partial Distal; With Roux-En-Y Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43644	Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb 150 Cm Or Less)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43645	Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43659	Unlisted Laparoscopy Procedure Stomach	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
43770	Laparoscopy Surgical Gastric Restrictive Procedure; Placement Of Adjustable Gastric Restrictive Device (Eg Gastric Band And Subcutaneous Port Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43771	Laparoscopy Surgical Gastric Restrictive Procedure; Revision Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43772	Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43773	Laparoscopy Surgical Gastric Restrictive Procedure; Removal And Replacement Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43774	Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device And Subcutaneous Port Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43775	Laparoscopy Surgical Gastric Restrictive Procedure; Longitudinal Gastrectomy (Ie Sleeve Gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43842	Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43843	Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Other Than Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43845	Gastric Restrictive Procedure With Partial Gastrectomy Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50 To 100 Cm Common Channel) To Limit Absorption (Biliopancreatic Diversion With Duodenal Switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43846	Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-Y Gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43847	Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

43848	Revision Open Of Gastric Restrictive Procedure For Morbid Obesity Other Than Adjustable Gastric Restrictive Device (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43886	Gastric Restrictive Procedure Open; Revision Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43887	Gastric Restrictive Procedure Open; Removal Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43888	Gastric Restrictive Procedure Open; Removal And Replacement Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
43999	Unlisted Procedure Stomach	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
44238	Unlisted Laparoscopy Procedure Intestine (Except Rectum)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
44799	Unlisted Procedure Small Intestine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
44899	Unlisted Procedure Meckel'S Diverticulum And The Mesentery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
44979	Unlisted Laparoscopy Procedure Appendix	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
45399	Unlisted Procedure Colon	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
45499	Unlisted Laparoscopy Procedure Rectum	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
45999	Unlisted Procedure Rectum	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
46707	Repair Of Anorectal Fistula With Plug (Eg Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
46999	Unlisted Procedure Anus	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
47370	Laparoscopy Surgical Ablation Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
47379	Unlisted Laparoscopic Procedure Liver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
47380	Ablation Open Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
47382	Ablation 1 Or More Liver Tumor(S) Percutaneous Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
47399	Unlisted Procedure Liver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

47579	Unlisted Laparoscopy Procedure Biliary Tract	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
47999	Unlisted Procedure Biliary Tract	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
48999	Unlisted Procedure Pancreas	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
49329	Unlisted Laparoscopy Procedure Abdomen Peritoneum And Omentum	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
49659	Unlisted Laparoscopy Procedure Hernioplasty Herniorrhaphy Herniotomy	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
49999	Unlisted Procedure Abdomen Peritoneum And Omentum	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
50250	Ablation Open 1 Or More Renal Mass Lesion(S) Cryosurgical Including Intraoperative Ultrasound Guidance And Monitoring If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
50360	Renal Allotransplantation Implantation Of Graft; Without Recipient Nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
50549	Unlisted Laparoscopy Procedure Renal	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
50592	Ablation 1 Or More Renal Tumor(S) Percutaneous Unilateral Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
50593	Ablation Renal Tumor(S) Unilateral Percutaneous Cryotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
50949	Unlisted Laparoscopy Procedure Ureter	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
51715	Endoscopic Injection Of Implant Material Into The Submucosal Tissues Of The Urethra And/Or Bladder Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
51999	Unlisted Laparoscopy Procedure Bladder	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
52284	Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
52284	Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
52327	Cystourethroscopy (Including Ureteral Catheterization); With Subureteric Injection Of Implant Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
52441	Cystourethroscopy With Insertion Of Permanent Adjustable Transprostatic Implant; Single Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

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.	_	_	_
53855	Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	5/14/2024	Retire effective 05/14/2024
53855	Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
53860	Transurethral Radiofrequency Micro-Remodeling Of The Female Bladder Neck And Proximal Urethra For Stress Urinary Incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
53899	Unlisted Procedure Urinary System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
54125	Amputation Of Penis; Complete	MP Criteria: Procedure/service reviewed against 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 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
54235	Injection Of Corpora Cavernosa With Pharmacologic Agent(S) (Eg Papaverine Phentolamine)	MP Criteria: Procedure/service reviewed against 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 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
54405	Insertion Of Multi-Component Inflatable Penile Prosthesis Including Placement Of Pump Cylinders And Reservoir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
54660	Insertion Of Testicular Prosthesis (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
54699	Unlisted Laparoscopy Procedure Testis	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
55559	Unlisted Laparoscopy Procedure Spermatic Cord	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

55880	Ablation Of Malignant Prostate Tissue Transrectal With High Intensity-Focused Ultrasound (Hifu) Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
55899	Unlisted Procedure Male Genital System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
55970	Intersex Surgery; Male To Female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
55980	Intersex Surgery; Female To Male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
56805	Clitoroplasty For Intersex State	MP Criteria: Procedure/service reviewed against 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 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 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
57335	Vaginoplasty For Intersex State	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
58578	Unlisted Laparoscopy Procedure Uterus	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
58579	Unlisted Hysteroscopy Procedure Uterus	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
58580	Transcervical Ablation Of Uterine Fibroid(S) Including Intraoperative Ultrasound Guidance And Monitoring Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
58679	Unlisted Laparoscopy Procedure Oviduct Ovary	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
58999	Unlisted Procedure Female Genital System (Nonobstetrical)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
59072	Fetal Umbilical Cord Occlusion Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

59074	Fetal Fluid Drainage (Eg Vesicocentesis Thoracocentesis Paracentesis) Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
59076	Fetal Shunt Placement Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
59897	Unlisted Fetal Invasive Procedure Including Ultrasound Guidance When Performed	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
59898	Unlisted Laparoscopy Procedure Maternity Care And Delivery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
59899	Unlisted Procedure Maternity Care And Delivery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
60659	Unlisted Laparoscopy Procedure Endocrine System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
60699	Unlisted Procedure Endocrine System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
61630	Balloon Angioplasty Intracranial (Eg Atherosclerotic Stenosis) Percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
61635	Transcatheter Placement Of Intravascular Stent(S) Intracranial (Eg Atherosclerotic Stenosis) Including Balloon Angioplasty If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
61645	Percutaneous Arterial Transluminal Mechanical Thrombectomy And/Or Infusion For Thrombolysis Intracranial Any Method Including Diagnostic Angiography Fluoroscopic Guidance Catheter Placement And Intraprocedural Pharmacological Thrombolytic Injection(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	_	Add effective 02/1/2024
61650	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Initial Vascular Territory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
61651	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Each Additional Vascular Territory (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024	Add effective 05/15/2024 Retire effective 06/30/2024
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
61889	Insertion Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver Including Craniectomy Or Craniotomy When Performed With Direct Or Inductive Coupling With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
61891	Revision Or Replacement Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
61892	Removal Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Cranioplasty When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
62263	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg Hypertonic Saline Enzyme) Or Mechanical Means (Eg Catheter) Including Radiologic Localization (Includes Contrast When Administered) Multiple Adhesiolysis Sessions; 2 Or More Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
62264	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg Hypertonic Saline Enzyme) Or Mechanical Means (Eg Catheter) Including Radiologic Localization (Includes Contrast When Administered) Multiple Adhesiolysis Sessions; 1 Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
62287	Decompression Procedure Percutaneous Of Nucleus Pulposus Of Intervertebral Disc Any Method Utilizing Needle Based Technique To Remove Disc Material Under Fluoroscopic Imaging Or Other Form Of Indirect Visualization With Discography And/Or Epidural Injection(S) At The Treated Level(S) When Performed Single Or Multiple Levels Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
64555	Percutaneous Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
64566	Posterior Tibial Neurostimulation Percutaneous Needle Electrode Single Treatment Includes Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
64568	Open Implantation Of Cranial Nerve (Eg Vagus Nerve) Neurostimulator Electrode Array And Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024

64575	Open Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
64582	Open Implantation Of Hypoglossal Nerve Neurostimulator Array Pulse Generator And Distal Respiratory Sensor Electrode Or Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
64590	Insertion Or Replacement Of Peripheral Sacral Or Gastric Neurostimulator Pulse Generator Or Receiver Requiring Pocket Creation And Connection Between Electrode Array And Pulse Generator Or Receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
64596	Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Initial Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
64597	Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Each Additional Electrode Array (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
64624	Destruction By Neurolytic Agent Genicular Nerve Branches Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
64628	Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; First 2 Vertebral Bodies Lumbar Or Sacral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
64629	Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; Each Additional Vertebral Body Lumbar Or Sacral (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
64640	Destruction By Neurolytic Agent; Other Peripheral Nerve Or Branch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
64999	Unlisted Procedure Nervous System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
65785	Implantation Of Intrastromal Corneal Ring Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

66174	Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); Without Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66175	Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); With Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66179	Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; Without Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66180	Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66183	Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir External Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66989	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1-Stage Procedure) Manual Or Mechanical Technique (Eg Irrigation And Aspiration Or Phacoemulsification) Complex Requiring Devices Or Techniques Not Generally Used In Routine Cataract Surgery (Eg Iris Expansion Device Suture Support For Intraocular Lens Or Primary Posterior Capsulorrhexis) Or Performed On Patients In The Amblyogenic Developmental Stage; With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach One Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66991	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1 Stage Procedure) Manual Or Mechanical Technique (Eg Irrigation And Aspiration Or Phacoemulsification); With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach One Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
66999	Unlisted Procedure Anterior Segment Of Eye	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67027	Implantation Of Intravitreal Drug Delivery System (Eg Ganciclovir Implant) Includes Concomitant Removal Of Vitreous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67299	Unlisted Procedure Posterior Segment	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67399	Unlisted Procedure Extraocular Muscle	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67516	Suprachoroidal Space Injection Of Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024

67599	Unlisted Procedure Orbit	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67900	Repair Of Brow Ptosis (Supraciliary Mid-Forehead Or Coronal Approach)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
67901	Repair Of Blepharoptosis; Frontalis Muscle Technique With Suture Or Other Material (Eg Banked Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67902	Repair Of Blepharoptosis; Frontalis Muscle Technique With Autologous Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67903	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement Internal Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67904	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement External Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67906	Repair Of Blepharoptosis; Superior Rectus Technique With Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67908	Repair Of Blepharoptosis; Conjunctivo-Tarso-Muller'S Muscle-Levator Resection (Eg Fasanella-Servat Type)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
67999	Unlisted Procedure Eyelids	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
68399	Unlisted Procedure Conjunctiva	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
68899	Unlisted Procedure Lacrimal System	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69090	Ear Piercing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69300	Otoplasty Protruding Ear With Or Without Size Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69399	Unlisted Procedure External Ear	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69705	Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69706	Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

69714	Implantation Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
69716	Implantation Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Resulting In Removal Of Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69717	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Percutaneous Attachment To External Speech Processor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
69719	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Involving A Bony Defect Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69728	Removal Entire Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69730	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
69799	Unlisted Procedure Middle Ear	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69930	Cochlear Device Implantation With Or Without Mastoidectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
69949	Unlisted Procedure Inner Ear	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
69979	Unlisted Procedure Temporal Bone Middle Fossa Approach	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
75894	Transcatheter Therapy Embolization Any Method Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	_	Add effective 02/1/2024

76496	Unlisted Fluoroscopic Procedure (Eg Diagnostic Interventional)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
76497	Unlisted Computed Tomography Procedure (Eg Diagnostic Interventional)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
76498	Unlisted Magnetic Resonance Procedure (Eg Diagnostic Interventional)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
76499	Unlisted Diagnostic Radiographic Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
76999	Unlisted Ultrasound Procedure (Eg Diagnostic Interventional)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
77299	Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
77399	Unlisted Procedure Medical Radiation Physics Dosimetry And Treatment Devices And Special Services	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
77499	Unlisted Procedure Therapeutic Radiology Treatment Management	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
77799	Unlisted Procedure Clinical Brachytherapy	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78099	Unlisted Endocrine Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78199	Unlisted Hematopoietic Reticuloendothelial And Lymphatic Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78299	Unlisted Gastrointestinal Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78399	Unlisted Musculoskeletal Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78499	Unlisted Cardiovascular Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78599	Unlisted Respiratory Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78699	Unlisted Nervous System Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78799	Unlisted Genitourinary Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
78999	Unlisted Miscellaneous Procedure Diagnostic Nuclear Medicine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
79999	Radiopharmaceutical Therapy Unlisted Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
80299	Quantitation Of Therapeutic Drug Not Elsewhere Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
81099	Unlisted Urinalysis Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
81479	Unlisted Molecular Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	–	–	–

81599	Unlisted Multianalyte Assay With Algorithmic Analysis	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
82523	Collagen Cross Links Any Method	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83006	Growth Stimulation Expressed Gene 2 (St2 Interleukin 1 Receptor Like-1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
83695	Lipoprotein (A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83698	Lipoprotein-Associated Phospholipase A2 (Lp-Pla2)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83701	Lipoprotein Blood; High Resolution Fractionation And Quantitation Of Lipoproteins Including Lipoprotein Subclasses When Performed (Eg Electrophoresis Ultracentrifugation)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83704	Lipoprotein Blood; Quantitation Of Lipoprotein Particle Number(S) (Eg By Nuclear Magnetic Resonance Spectroscopy) Includes Lipoprotein Particle Subclass(Es) When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83722	Lipoprotein Direct Measurement; Small Dense Ldl Cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83937	Osteocalcin (Bone G1A Protein)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83987	Ph; Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
84112	Evaluation Of Cervicovaginal Fluid For Specific Amniotic Fluid Protein(S) (Eg Placental Alpha Microglobulin-1 [Pamg-1] Placental Protein 12 [Pp12] Alpha-Fetoprotein) Qualitative Each Specimen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
84431	Thromboxane Metabolite(S) Including Thromboxane If Performed Urine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
84999	Unlisted Chemistry Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

85999	Unlisted Hematology And Coagulation Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
86001	Allergen Specific Igg Quantitative Or Semiquantitative Each Allergen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86328	Immunoassay For Infectious Agent Antibody(Ies) Qualitative Or Semiquantitative Single-Step Method (Eg Reagent Strip); Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86343	Leukocyte Histamine Release Test (Lhr)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86352	Cellular Function Assay Involving Stimulation (Eg Mitogen Or Antigen) And Detection Of Biomarker (Eg Atp)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
86353	Lymphocyte Transformation Mitogen (Phytomitogen) Or Antigen Induced Blastogenesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
86408	Neutralizing Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Screen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86409	Neutralizing Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Titer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86413	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Antibody Quantitative	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86486	Skin Test; Unlisted Antigen Each	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
86769	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
86849	Unlisted Immunology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
86910	Blood Typing For Paternity Testing Per Individual; Abo Rh And Mn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
86911	Blood Typing For Paternity Testing Per Individual; Each Additional Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

86950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
86999	Unlisted Transfusion Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87505	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 3-5 Targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
87506	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 6-11 Targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
87507	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 12-25 Targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
87797	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Direct Probe Technique Each Organism	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87798	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Amplified Probe Technique Each Organism	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87799	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Quantification Each Organism	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87899	Infectious Agent Antigen Detection By Immunoassay With Direct Optical (Ie Visual) Observation; Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
87999	Unlisted Microbiology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88000	Necropsy (Autopsy) Gross Examination Only; Without Cns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88005	Necropsy (Autopsy) Gross Examination Only; With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88007	Necropsy (Autopsy) Gross Examination Only; With Brain And Spinal Cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88012	Necropsy (Autopsy) Gross Examination Only; Infant With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88014	Necropsy (Autopsy) Gross Examination Only; Stillborn Or Newborn With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

88016	Necropsy (Autopsy) Gross Examination Only; Macerated Stillborn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88020	Necropsy (Autopsy) Gross And Microscopic; Without Cns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88025	Necropsy (Autopsy) Gross And Microscopic; With Brain	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
88028	Necropsy (Autopsy) Gross And Microscopic; Infant With Brain	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
88036	Necropsy (Autopsy) Limited Gross And/Or Microscopic; Regional	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
88040	Necropsy (Autopsy); Forensic Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88045	Necropsy (Autopsy); Coroner'S Call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
88099	Unlisted Necropsy (Autopsy) Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88199	Unlisted Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88299	Unlisted Cytogenetic Study	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88375	Optical Endomicroscopic Image(S) Interpretation And Report Real-Time Or Referred Each Endoscopic Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
88399	Unlisted Surgical Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
88749	Unlisted In Vivo (Eg Transcutaneous) Laboratory Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
89240	Unlisted Miscellaneous Pathology Test	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

89258	Cryopreservation; Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		4/23/2024	Retire effective 4/23/2024
89258	Cryopreservation; Embryo(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/24/2024	_	Effective 4/24/2024
89259	Cryopreservation; Sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89335	Cryopreservation Reproductive Tissue Testicular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89337	Cryopreservation Mature Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89342	Storage (Per Year); Embryo(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89343	Storage (Per Year); Sperm/Semen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89344	Storage (Per Year); Reproductive Tissue Testicular/Ovarian	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
89346	Storage (Per Year); Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		4/23/2024	Retire effective 4/23/2024
89346	Storage (Per Year); Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/24/2024	_	Effective 4/24/2024
89398	Unlisted Reproductive Medicine Laboratory Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
90378	Respiratory Syncytial Virus Monoclonal Antibody Recombinant For Intramuscular Use 50 Mg Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
90399	Unlisted Immune Globulin	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
90584	Dengue Vaccine Quadrivalent Live 2 Dose Schedule For Subcutaneous Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90689	Influenza Virus Vaccine Quadrivalent (Iiv4) Inactivated Adjuvanted Preservative Free 0.25 Ml Dosage For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90749	Unlisted Vaccine/Toxoid	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

90867	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Initial Including Cortical Mapping Motor Threshold Determination Delivery And Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90868	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Delivery And Management Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90869	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Motor Threshold Re-Determination With Delivery And Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90875	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient) With Psychotherapy (Eg Insight Oriented Behavior Modifying Or Supportive Psychotherapy); 30 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90876	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient) With Psychotherapy (Eg Insight Oriented Behavior Modifying Or Supportive Psychotherapy); 45 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	5/31/2024	Retire effective 5/31/2024
90885	Psychiatric Evaluation Of Hospital Records Other Psychiatric Reports Psychometric And/Or Projective Tests And Other Accumulated Data For Medical Diagnostic Purposes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90889	Preparation Of Report Of Patient'S Psychiatric Status History Treatment Or Progress (Other Than For Legal Or Consultative Purposes) For Other Individuals Agencies Or Insurance Carriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
90899	Unlisted Psychiatric Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
90901	Biofeedback Training By Any Modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90912	Biofeedback Training Perineal Muscles Anorectal Or Urethral Sphincter Including Emg And/Or Manometry When Performed; Initial 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
90913	Biofeedback Training Perineal Muscles Anorectal Or Urethral Sphincter Including Emg And/Or Manometry When Performed; Each Additional 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

90999	Unlisted Dialysis Procedure Inpatient Or Outpatient	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
91034	Esophagus Gastroesophageal Reflux Test; With Nasal Catheter Ph Electrode(S) Placement Recording Analysis And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91035	Esophagus Gastroesophageal Reflux Test; With Mucosal Attached Telemetry Ph Electrode Placement Recording Analysis And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91037	Esophageal Function Test Gastroesophageal Reflux Test With Nasal Catheter Intraluminal Impedance Electrode(S) Placement Recording Analysis And Interpretation;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91038	Esophageal Function Test Gastroesophageal Reflux Test With Nasal Catheter Intraluminal Impedance Electrode(S) Placement Recording Analysis And Interpretation; Prolonged (Greater Than 1 Hour Up To 24 Hours)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91065	Breath Hydrogen Or Methane Test (Eg For Detection Of Lactase Deficiency Fructose Intolerance Bacterial Overgrowth Or Oro-Cecal Gastrointestinal Transit)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
91110	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Esophagus Through Ileum With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91111	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Esophagus With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
91112	Gastrointestinal Transit And Pressure Measurement Stomach Through Colon Wireless Capsule With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
91113	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Colon With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
91117	Colon Motility (Manometric) Study Minimum 6 Hours Continuous Recording (Including Provocation Tests Eg Meal Intracolonic Balloon Distension Pharmacologic Agents If Performed) With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
91132	Electrogastrography Diagnostic Transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
91133	Electrogastrography Diagnostic Transcutaneous; With Provocative Testing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

91299	Unlisted Diagnostic Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
92015	Determination Of Refractive State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92065	Orthoptic Training; Performed By A Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92132	Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment With Interpretation And Report Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92145	Corneal Hysteresis Determination By Air Impulse Stimulation Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92340	Fitting Of Spectacles Except For Aphakia; Monofocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92341	Fitting Of Spectacles Except For Aphakia; Bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92342	Fitting Of Spectacles Except For Aphakia; Multifocal Other Than Bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92354	Fitting Of Spectacle Mounted Low Vision Aid; Single Element System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92355	Fitting Of Spectacle Mounted Low Vision Aid; Telescopic Or Other Compound Lens System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92370	Repair And Refitting Spectacles; Except For Aphakia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
92499	Unlisted Ophthalmological Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
92512	Nasal Function Studies (Eg Rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92517	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Cervical (Cvemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92518	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Ocular (Ovemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92519	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Cervical (Cvemp) And Ocular (Ovemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92546	Sinusoidal Vertical Axis Rotational Testing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

92548	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot) 6 Conditions (Ie Eyes Open Eyes Closed Visual Sway Platform Sway Eyes Closed Platform Sway Platform And Visual Sway) Including Interpretation And Report;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92549	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot) 6 Conditions (Ie Eyes Open Eyes Closed Visual Sway Platform Sway Eyes Closed Platform Sway Platform And Visual Sway) Including Interpretation And Report; With Motor Control Test (Mct) And Adaptation Test (Adt)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
92622	Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; First 60 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
92623	Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
92640	Diagnostic Analysis With Programming Of Auditory Brainstem Implant Per Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
92700	Unlisted Otorhinolaryngological Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
92972	Percutaneous Transluminal Coronary Lithotripsy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
93050	Arterial Pressure Waveform Analysis For Assessment Of Central Arterial Pressures Includes Obtaining Waveform(S) Digitization And Application Of Nonlinear Mathematical Transformations To Determine Central Arterial Pressures And Augmentation Index With Interpretation And Report Upper Extremity Artery Non-Invasive	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024

93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
93152	Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	–	Add effective 05/15/2024
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	Add effective 02/15/2024 Retire effective 05/14/2024
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	–	Add effective 05/15/2024
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	Add effective 02/15/2024 Retire effective 05/14/2024
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.	_	_	_
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.	_	_	_
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.	_	_	_

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.	_	_	_
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).	_	_	_
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
93797	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; Without Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
93798	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; With Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
93799	Unlisted Cardiovascular Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
93998	Unlisted Noninvasive Vascular Diagnostic Study	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
94014	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Includes Reinforced Education Transmission Of Spirometric Tracing Data Capture Analysis Of Transmitted Data Periodic Recalibration And Review And Interpretation By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
94015	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Recording (Includes Hook-Up Reinforced Education Data Transmission Data Capture Trend Analysis And Periodic Recalibration)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
94016	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Review And Interpretation Only By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
94452	High Altitude Simulation Test (Hast) With Interpretation And Report By A Physician Or Other Qualified Health Care Professional;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
94453	High Altitude Simulation Test (Hast) With Interpretation And Report By A Physician Or Other Qualified Health Care Professional; With Supplemental Oxygen Titration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
94799	Unlisted Pulmonary Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

95060	Ophthalmic Mucous Membrane Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
95065	Direct Nasal Mucous Membrane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
95199	Unlisted Allergy/Clinical Immunologic Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
95700	Electroencephalogram (Eeg) Continuous Recording With Video When Performed Setup Patient Education And Takedown When Performed Administered In Person By Eeg Technologist Minimum Of 8 Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95705	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95706	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95707	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95708	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95709	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95710	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95711	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95712	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95713	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

95714	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95715	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95716	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95717	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 Hours Of Eeg Recording; Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95718	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 Hours Of Eeg Recording; With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95719	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period; Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95720	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period; With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95721	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95722	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

95723	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95724	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
95726	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95803	Actigraphy Testing Recording Analysis Interpretation And Report (Minimum Of 72 Hours To 14 Consecutive Days Of Recording)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95905	Motor And/Or Sensory Nerve Conduction Using Preconfigured Electrode Array(S) Amplitude And Latency/Velocity Study Each Limb Includes F-Wave Study When Performed With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
95919	Quantitative Pupillometry With Physician Or Other Qualified Health Care Professional Interpretation And Report Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
95954	Pharmacological Or Physical Activation Requiring Physician Or Other Qualified Health Care Professional Attendance During Eeg Recording Of Activation Phase (Eg Thiopental Activation Test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95957	Digital Analysis Of Electroencephalogram (Eeg) (Eg For Epileptic Spike Analysis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

95962	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface Or Of Depth Electrodes To Provoke Seizures Or Identify Vital Brain Structures; Each Additional Hour Of Attendance By A Physician Or Other Qualified Health Care Professional (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
95965	Magnetoencephalography (Meg) Recording And Analysis; For Spontaneous Brain Magnetic Activity (Eg Epileptic Cerebral Cortex Localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95966	Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Single Modality (Eg Sensory Motor Language Or Visual Cortex Localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95967	Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Each Additional Modality (Eg Sensory Motor Language Or Visual Cortex Localization) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95981	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent Without Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95982.00	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent With Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
95999	Unlisted Neurological Or Neuromuscular Diagnostic Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
96000	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96001	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics; With Dynamic Plantar Pressure Measurements During Walking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96002	Dynamic Surface Electromyography During Walking Or Other Functional Activities 1-12 Muscles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96003	Dynamic Fine Wire Electromyography During Walking Or Other Functional Activities 1 Muscle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

96004	Review And Interpretation By Physician Or Other Qualified Health Care Professional Of Comprehensive Computer-Based Motion Analysis Dynamic Plantar Pressure Measurements Dynamic Surface Electromyography During Walking Or Other Functional Activities And Dynamic Fine Wire Electromyography With Written Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96379	Unlisted Therapeutic Prophylactic Or Diagnostic Intravenous Or Intra-Arterial Injection Or Infusion	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
96547	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure Including Separate Incision(S) And Closure When Performed; First 60 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
96548	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure Including Separate Incision(S) And Closure When Performed; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
96549	Unlisted Chemotherapy Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
96912	Photochemotherapy; Psoralens And Ultraviolet A (Puva)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96913	Photochemotherapy (Goeckerman And/Or Puva) For Severe Photoresponsive Dermatoses Requiring At Least 4-8 Hours Of Care Under Direct Supervision Of The Physician (Includes Application Of Medication And Dressings)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96922	Excimer Laser Treatment For Psoriasis; Over 500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96931	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition And Interpretation And Report First Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96932	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition Only First Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96933	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Interpretation And Report Only First Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
96934	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition And Interpretation And Report Each Additional Lesion (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.	_	_	_

96935	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition Only Each Additional Lesion (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.	_	_	_
96936	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Interpretation And Report Only Each Additional Lesion (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.	_	_	_
96999	Unlisted Special Dermatological Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
97037	Application Of A Modality To 1 Or More Areas; Low-Level Laser Therapy (Ie Nonthermal And Non-Ablative) For Post-Operative Pain Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
97039	Unlisted Modality (Specify Type And Time If Constant Attendance)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
97139	Unlisted Therapeutic Procedure (Specify)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
97169	Athletic Training Evaluation Low Complexity Requiring These Components: A History And Physical Activity Profile With No Comorbidities That Affect Physical Activity; An Examination Of Affected Body Area And Other Symptomatic Or Related Systems Addressing 1-2 Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; And Clinical Decision Making Of Low Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 15 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97170	Athletic Training Evaluation Moderate Complexity Requiring These Components: A Medical History And Physical Activity Profile With 1-2 Comorbidities That Affect Physical Activity; An Examination Of Affected Body Area And Other Symptomatic Or Related Systems Addressing A Total Of 3 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; And Clinical Decision Making Of Moderate Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 30 Minutes Are Spent Face-To-Face With The Patient And/Or Family	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

97171	Athletic Training Evaluation High Complexity Requiring These Components: A Medical History And Physical Activity Profile With 3 Or More Comorbidities That Affect Physical Activity; A Comprehensive Examination Of Body Systems Using Standardized Tests And Measures Addressing A Total Of 4 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; Clinical Presentation With Unstable And Unpredictable Characteristics; And Clinical Decision Making Of High Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 45 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97172	Re-Evaluation Of Athletic Training Established Plan Of Care Requiring These Components: An Assessment Of Patient'S Current Functional Status When There Is A Documented Change; And A Revised Plan Of Care Using A Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome With An Update In Management Options Goals And Interventions. Typically 20 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
97533	Sensory Integrative Techniques To Enhance Sensory Processing And Promote Adaptive Responses To Environmental Demands Direct (One-On-One) Patient Contact Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
97537	Community/Work Reintegration Training (Eg Shopping Transportation Money Management Avocational Activities And/Or Work Environment/Modification Analysis Work Task Analysis Use Of Assistive Technology Device/Adaptive Equipment) Direct One-On-One Contact Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
97610	Low Frequency Non-Contact Non-Thermal Ultrasound Including Topical Application(S) When Performed Wound Assessment And Instruction(S) For Ongoing Care Per Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
97799	Unlisted Physical Medicine/Rehabilitation Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	Retire effective 2/29/2024

99024	Postoperative Follow-Up Visit Normally Included In The Surgical Package To Indicate That An Evaluation And Management Service Was Performed During A Postoperative Period For A Reason(S) Related To The Original Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
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.	_	_	_
99050	Services Provided In The Office At Times Other Than Regularly Scheduled Office Hours Or Days When The Office Is Normally Closed (Eg Holidays Saturday Or Sunday) In Addition To Basic Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99056	Service(S) Typically Provided In The Office Provided Out Of The Office At Request Of Patient In Addition To Basic Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99058	Service(S) Provided On An Emergency Basis In The Office Which Disrupts Other Scheduled Office Services In Addition To Basic Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99070	Supplies And Materials (Except Spectacles) Provided By The Physician Or Other Qualified Health Care Professional Over And Above Those Usually Included With The Office Visit Or Other Services Rendered (List Drugs Trays Supplies Or Materials Provided)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	_
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99078	Physician Or Other Qualified Health Care Professional Qualified By Education Training Licensure/Regulation (When Applicable) Educational Services Rendered To Patients In A Group Setting (Eg Prenatal Obesity Or Diabetic Instructions)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99082	Unusual Travel (Eg Transportation And Escort Of Patient)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99199	Unlisted Special Service Procedure Or Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

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.	–	–	–
99429	Unlisted Preventive Medicine Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
99446	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 5-10 Minutes Of Medical Consultative Discussion And Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99447	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 11-20 Minutes Of Medical Consultative Discussion And Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99448	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 21-30 Minutes Of Medical Consultative Discussion And Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99449	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Verbal And Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional; 31 Minutes Or More Of Medical Consultative Discussion And Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99450	Basic Life And/Or Disability Examination That Includes: Measurement Of Height Weight And Blood Pressure; Completion Of A Medical History Following A Life Insurance Pro Forma; Collection Of Blood Sample And/Or Urinalysis Complying With Chain Of Custody Protocols; And Completion Of Necessary Documentation/Certificates.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

99451	Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician Or Other Qualified Health Care Professional Including A Written Report To The Patient'S Treating/Requesting Physician Or Other Qualified Health Care Professional 5 Minutes Or More Of Medical Consultative Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99452	Interprofessional Telephone/Internet/Electronic Health Record Referral Service(S) Provided By A Treating/Requesting Physician Or Other Qualified Health Care Professional 30 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99453	Remote Monitoring Of Physiologic Parameter(S) (Eg Weight Blood Pressure Pulse Oximetry Respiratory Flow Rate) Initial; Set-Up And Patient Education On Use Of Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99454	Remote Monitoring Of Physiologic Parameter(S) (Eg Weight Blood Pressure Pulse Oximetry Respiratory Flow Rate) Initial; Device(S) Supply With Daily Recording(S) Or Programmed Alert(S) Transmission Each 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
99456	Work Related Or Medical Disability Examination By Other Than The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis Assessment Of Capabilities And Stability And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
99457	Remote Physiologic Monitoring Treatment Management Services Clinical Staff/Physician/Other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/Caregiver During The Month; First 20 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

99491	Chronic Care Management Services With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months Or Until The Death Of The Patient Chronic Conditions That Place The Patient At Significant Risk Of Death Acute Exacerbation/Decompensation Or Functional Decline Comprehensive Care Plan Established Implemented Revised Or Monitored; First 30 Minutes Provided Personally By A Physician Or Other Qualified Health Care Professional Per Calendar Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
99499	Unlisted Evaluation And Management Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99600	Unlisted Home Visit Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
0052U	Lipoprotein Blood High Resolution Fractionation And Quantitation Of Lipoproteins Including All Five Major Lipoprotein Classes And Subclasses Of Hdl Ldl And Vldl By Vertical Auto Profile Ultracentrifugation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0054T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Fluoroscopic Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0055T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Ct/Mri Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0062U	Autoimmune (Systemic Lupus Erythematosus) Igg And Igm Analysis Of 80 Biomarkers Utilizing Serum Algorithm Reported With A Risk Score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0063U	Neurology (Autism) 32 Amines By Lc-Ms/Ms Using Plasma Algorithm Reported As Metabolic Signature Associated With Autism Spectrum Disorder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0071T	Focused Ultrasound Ablation Of Uterine Leiomyomata Including Mr Guidance; Total Leiomyomata Volume Less Than 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0072T	Focused Ultrasound Ablation Of Uterine Leiomyomata Including Mr Guidance; Total Leiomyomata Volume Greater Or Equal To 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0075T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S) Including Radiologic Supervision And Interpretation Open Or Percutaneous; Initial Vessel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

0076T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S) Including Radiologic Supervision And Interpretation Open Or Percutaneous; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0084U	Red Blood Cell Antigen Typing Dna Genotyping Of 10 Blood Groups With Phenotype Prediction Of 37 Red Blood Cell Antigens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0086U	Infectious Disease (Bacterial And Fungal) Organism Identification Blood Culture Using Rrna Fish 6 Or More Organism Targets Reported As Positive Or Negative With Phenotypic Minimum Inhibitory Concentration (Mic)-Based Antimicrobial Susceptibility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0091U	Oncology (Colorectal) Screening Cell Enumeration Of Circulating Tumor Cells Utilizing Whole Blood Algorithm For The Presence Of Adenoma Or Cancer Reported As A Positive Or Negative Result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0092U	Oncology (Lung) Three Protein Biomarkers Immunoassay Using Magnetic Nanosensor Technology Plasma Algorithm Reported As Risk Score For Likelihood Of Malignancy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0093U	Prescription Drug Monitoring Evaluation Of 65 Common Drugs By Lc-Ms/Ms Urine Each Drug Reported Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0095U	Eosinophilic Esophagitis (Eotaxin-3 [Ccl26 {C-C Motif Chemokine Ligand 26}] And Major Basic Protein [Prg2 {Proteoglycan 2 Pro Eosinophil Major Basic Protein}] Enzyme-Linked Immunosorbent Assays (Elisa) Specimen Obtained By Esophageal String Test Device Algorithm Reported As Probability Of Active Or Inactive Eosinophilic Esophagitis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0096U	Human Papillomavirus (Hpv) High-Risk Types (Ie 16 18 31 33 35 39 45 51 52 56 58 59 66 68) Male Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0100T	Placement Of A Subconjunctival Retinal Prosthesis Receiver And Pulse Generator And Implantation Of Intraocular Retinal Electrode Array With Vitrectomy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0101T	Extracorporeal Shock Wave Involving Musculoskeletal System Not Otherwise Specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0102T	Extracorporeal Shock Wave Performed By A Physician Requiring Anesthesia Other Than Local And Involving The Lateral Humeral Epicondyle	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0105U	Nephrology (Chronic Kidney Disease) Multiplex Electrochemiluminescent Immunoassay (Eclia) Of Tumor Necrosis Factor Receptor 1A Receptor Superfamily 2 (Tnfr1 Tnfr2) And Kidney Injury Molecule-1 (Kim-1) Combined With Longitudinal Clinical Data Including Apol1 Genotype If Available And Plasma (Isolated Fresh Or Frozen) Algorithm Reported As Probability Score For Rapid Kidney Function Decline (Rkfd)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0106T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Touch Pressure Stimuli To Assess Large Diameter Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0106U	Gastric Emptying Serial Collection Of 7 Timed Breath Specimens Non-Radioisotope Carbon-13 (13C) Spirulina Substrate Analysis Of Each Specimen By Gas Isotope Ratio Mass Spectrometry Reported As Rate Of 13Co2 Excretion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0107T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Vibration Stimuli To Assess Large Diameter Fiber Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0107U	Clostridium Difficile Toxin(S) Antigen Detection By Immunoassay Technique Stool Qualitative Multiple-Step Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0108T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Cooling Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0108U	Gastroenterology (Barrett'S Esophagus) Whole Slide–Digital Imaging Including Morphometric Analysis Computer-Assisted Quantitative Immunolabeling Of 9 Protein Biomarkers (P16 Amacr P53 Cd68 Cox-2 Cd45Ro Hif1A Her-2 K20) And Morphology Formalin-Fixed Paraffin-Embedded Tissue Algorithm Reported As Risk Of Progression To High-Grade Dysplasia Or Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0109T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Heat-Pain Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0109U	Infectious Disease (Aspergillus Species) Real-Time Pcr For Detection Of Dna From 4 Species (A. Fumigatus A. Terreus A. Niger And A. Flavus) Blood Lavage Fluid Or Tissue Qualitative Reporting Of Presence Or Absence Of Each Species	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

0110T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Other Stimuli To Assess Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0110U	Prescription Drug Monitoring One Or More Oral Oncology Drug(S) And Substances Definitive Tandem Mass Spectrometry With Chromatography Serum Or Plasma From Capillary Blood Or Venous Blood Quantitative Report With Steady-State Range For The Prescribed Drug(S) When Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0112U	Infectious Agent Detection And Identification Targeted Sequence Analysis (16S And 18S Rrna Genes) With Drug-Resistance Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0115U	Respiratory Infectious Agent Detection By Nucleic Acid (Dna And Rna) 18 Viral Types And Subtypes And 2 Bacterial Targets Amplified Probe Technique Including Multiplex Reverse Transcription For Rna Targets Each Analyte Reported As Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0116U	Prescription Drug Monitoring Enzyme Immunoassay Of 35 Or More Drugs Confirmed With Lc-Ms/Ms Oral Fluid Algorithm Results Reported As A Patient-Compliance Measurement With Risk Of Drug To Drug Interactions For Prescribed Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0117U	Pain Management Analysis Of 11 Endogenous Analytes (Methylmalonic Acid Xanthurenic Acid Homocysteine Pyroglutamic Acid Vanilmandelate 5-Hydroxyindoleacetic Acid Hydroxymethylglutarate Ethylmalonate 3-Hydroxypropyl Mercapturic Acid (3-Hpma) Quinolinic Acid Kynurenic Acid) Lc-Ms/Ms Urine Algorithm Reported As A Pain-Index Score With Likelihood Of Atypical Biochemical Function Associated With Pain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0119U	Cardiology Ceramides By Liquid Chromatography–Tandem Mass Spectrometry Plasma Quantitative Report With Risk Score For Major Cardiovascular Events	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0121U	Sickle Cell Disease Microfluidic Flow Adhesion (Vcam-1) Whole Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0122U	Sickle Cell Disease Microfluidic Flow Adhesion (P-Selectin) Whole Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0123U	Mechanical Fragility Rbc Shear Stress And Spectral Analysis Profiling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0140U	Infectious Disease (Fungi) Fungal Pathogen Identification Dna (15 Fungal Targets) Blood Culture Amplified Probe Technique Each Target Reported As Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

0141U	Infectious Disease (Bacteria And Fungi) Gram-Positive Organism Identification And Drug Resistance Element Detection Dna (20 Gram-Positive Bacterial Targets 4 Resistance Genes 1 Pan Gram-Negative Bacterial Target 1 Pan Candida Target) Blood Culture Amplified Probe Technique Each Target Reported As Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0142U	Infectious Disease (Bacteria And Fungi) Gram-Positive Organism Identification And Drug Resistance Element Detection Dna (20 Gram-Positive Bacterial Targets 4 Resistance Genes 1 Pan Gram-Negative Bacterial Target 1 Pan Candida Target) Blood Culture Amplified Probe Technique Each Target Reported As Detected Or Not Detected	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0152U	Infectious Disease (Bacteria Fungi Parasites And Dna Viruses) Microbial Cell-Free Dna Plasma Untargeted Next-Generation Sequencing Report For Significant Positive Pathogens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0198T	Measurement Of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0200T	Percutaneous Sacral Augmentation (Sacroplasty) Unilateral Injection(S) Including The Use Of A Balloon Or Mechanical Device When Used 1 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0201T	Percutaneous Sacral Augmentation (Sacroplasty) Bilateral Injections Including The Use Of A Balloon Or Mechanical Device When Used 2 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0202T	Posterior Vertebral Joint(S) Arthroplasty (Eg Facet Joint[S] Replacement) Including Facetectomy Laminectomy Foraminotomy And Vertebral Column Fixation Injection Of Bone Cement When Performed Including Fluoroscopy Single Level Lumbar Spine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0207T	Evacuation Of Meibomian Glands Automated Using Heat And Intermittent Pressure Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0219T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0220T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0221T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0222T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0224U	Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Includes Titer(S) When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0226U	Surrogate Viral Neutralization Test (Svnt) Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Elisa Plasma Seru	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0232T	Injection(S) Platelet Rich Plasma Any Site Including Image Guidance Harvesting And Preparation When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0253T	Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Suprachoroidal Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0263T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Including Unilateral Or Bilateral Bone Marrow Harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0264T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Excluding Bone Marrow Harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0265T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Unilateral Or Bilateral Bone Marrow Harvest Only For Intramuscular Autologous Bone Marrow Cell Therapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0266T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement Unilateral Or Bilateral Lead Placement Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

0267T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Lead Only Unilateral (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0268T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0269T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement Unilateral Or Bilateral Lead Placement Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0270T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Lead Only Unilateral (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0271T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0272T	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day):	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0273T	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day); With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral; Cervical Or Thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral; Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg Scrambler Therapy) Each Treatment Session (Includes Placement Of Electrodes)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0308T	Insertion Of Ocular Telescope Prosthesis Including Removal Of Crystalline Lens Or Intraocular Lens Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
0322U	Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	1/14/2024	Add effective 10/15/2023 Retire effective 02/01/2024
0322U	Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999	Add effective 02/01/2024
0330T	Tear Film Imaging Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0331T	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0332T	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment; With Tomographic Spect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0335T	Insertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0338T	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed; Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0339T	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed; Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach Via The Coronary Sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0347T	Placement Of Interstitial Device(S) In Bone For Radiostereometric Analysis (Rsa)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0348T	Radiologic Examination Radiostereometric Analysis (Rsa); Spine (Includes Cervical Thoracic And Lumbosacral When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0349T	Radiologic Examination Radiostereometric Analysis (Rsa); Upper Extremity(Ies) (Includes Shoulder Elbow And Wrist When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0350T	Radiologic Examination Radiostereometric Analysis (Rsa); Lower Extremity(Ies) (Includes Hip Proximal Femur Knee And Ankle When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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	Add effective 02/01/2024 Retire effective 05/14/2024
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	_	Add effective 05/015/2024

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).	_	_	_
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).	_	_	_
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).	_	_	_
0398T	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (Mrgfus) Stereotactic Ablation Lesion Intracranial For Movement Disorder Including Stereotactic Navigation And Frame Placement When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0408T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator With Transvenous Electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0409T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0410T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Atrial Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0411T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Ventricular Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0412T	Removal Of Permanent Cardiac Contractility Modulation System; Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0413T	Removal Of Permanent Cardiac Contractility Modulation System; Transvenous Electrode (Atrial Or Ventricular)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024

0414T	Removal And Replacement Of Permanent Cardiac Contractility Modulation System Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0415T	Repositioning Of Previously Implanted Cardiac Contractility Modulation Transvenous Electrode (Atrial Or Ventricular Lead)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0416T	Relocation Of Skin Pocket For Implanted Cardiac Contractility Modulation Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0417T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Including Review And Report Implantable Cardiac Contractility Modulation System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0418T	Interrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording And Disconnection Per Patient Encounter Implantable Cardiac Contractility Modulation System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0422T	Tactile Breast Imaging By Computer-Aided Tactile Sensors Unilateral Or Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0440T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Upper Extremity Distal/Peripheral Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
0441T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Lower Extremity Distal/Peripheral Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
0442T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Nerve Plexus Or Other Truncal Nerve (Eg Brachial Plexus Pudendal Nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
0449T	Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Initial Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0450T	Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Each Additional Device (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0464T	Visual Evoked Potential Testing For Glaucoma With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0472T	Device Evaluation Interrogation And Initial Programming Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person With Iterative Adjustment Of The Implantable Device To Test Functionality Select Optimal Permanent Programmed Values With Analysis Including Visual Training With Review And Report By A Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0473T	Device Evaluation And Interrogation Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person Including Reprogramming And Visual Training When Performed With Review And Report By A Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0474T	Insertion Of Anterior Segment Aqueous Drainage Device With Creation Of Intraocular Reservoir Internal Approach Into The Supraciliary Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0479T	Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; First 100 Cm2 Or Part Thereof Or 1% Of Body Surface Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0480T	Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; Each Additional 100 Cm2 Or Each Additional 1% Of Body Surface Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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).	_	_	_
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.	2/1/2024	_	Add effective 02/01/2024

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.	2/1/2024	_	Add effective 02/01/2024
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.	2/1/2024	_	Add effective 02/01/2024
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).	_	_	_
0509T	Electroretinography (Erg) With Interpretation And Report Pattern (Perg)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0511T	Removal And Reinsertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0512T	Extracorporeal Shock Wave For Integumentary Wound Healing Including Topical Application And Dressing Care; Initial Wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0513T	Extracorporeal Shock Wave For Integumentary Wound Healing Including Topical Application And Dressing Care; Each Additional Wound (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0524T	Endovenous Catheter Directed Chemical Ablation With Balloon Isolation Of Incompetent Extremity Vein Open Or Percutaneous Including All Vascular Access Catheter Manipulation Diagnostic Imaging Imaging Guidance And Monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

0537T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Harvesting Of Blood-Derived T Lymphocytes For Development Of Genetically Modified Autologous Car-T Cells Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Preparation Of Blood-Derived T Lymphocytes For Transportation (Eg Cryopreservation Storage)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0539T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt And Preparation Of Car-T Cells For Administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Car-T Cell Administration Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0544T	Transcatheter Mitral Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device Percutaneous Approach Including Transseptal Puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0545T	Transcatheter Tricuspid Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device Percutaneous Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0546T	Radiofrequency Spectroscopy Real Time Intraoperative Margin Assessment At The Time Of Partial Mastectomy With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0563T	Evacuation Of Meibomian Glands Using Heat Delivered Through Wearable Open-Eye Eyelid Treatment Devices And Manual Gland Expression Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0565T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Tissue Harvesting And Cellular Implant Creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0566T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Injection Of Cellular Implant Into Knee Joint Including Ultrasound Guidance Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0569T	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0570T	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Each Additional Prosthesis During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

0587T	Percutaneous Implantation Or Replacement Of Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0588T	Revision Or Removal Of Percutaneously Placed Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0589T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0590T	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 4 Or More Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0596T	Temporary Female Intraurethral Valve-Pump (Ie Voiding Prosthesis); Initial Insertion Including Urethral Measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0597T	Temporary Female Intraurethral Valve-Pump (Ie Voiding Prosthesis); Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And Drug Delivery Including Transrectal Ultrasound And Fluoroscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And Drug Delivery Including Transrectal Ultrasound And Fluoroscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0620T	Endovascular Venous Arterialization Tibial Or Peroneal Vein With Transcatheter Placement Of Intravascular Stent Graft(S) And Closure By Any Method Including Percutaneous Or Open Vascular Access Ultrasound Guidance For Vascular Access When Performed All Catheterization(S) And Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention All Associated Radiological Supervision And Interpretation When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
0626T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease Using Data From Coronary Computed Tomographic Angiography; Review Of Computerized Analysis Output To Reconcile Discordant Data Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0627T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Fluoroscopic Guidance Lumbar; First Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0628T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Fluoroscopic Guidance Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0629T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Ct Guidance Lumbar; First Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0630T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Ct Guidance Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0631T	Transcutaneous Visible Light Hyperspectral Imaging Measurement Of Oxyhemoglobin Deoxyhemoglobin And Tissue Oxygenation With Interpretation And Report Per Extremity	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0632T	Percutaneous Transcatheter Ultrasound Ablation Of Nerves Innervating The Pulmonary Arteries Including Right Heart Catheterization Pulmonary Artery Angiography And All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0639T	Wireless Skin Sensor Thermal Anisotropy Measurement(S) And Assessment Of Flow In Cerebrospinal Fluid Shunt Including Ultrasound Guidance When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0640T	Noncontact Near-Infrared Spectroscopy (Eg For Measurement Of Deoxyhemoglobin Oxyhemoglobin And Ratio Of Tissue Oxygenation) Other Than For Screening For Peripheral Arterial Disease Image Acquisition Interpretation And Report; First Anatomic Site	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0643T	Transcatheter Left Ventricular Restoration Device Implantation Including Right And Left Heart Catheterization And Left Ventriculography When Performed Arterial Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0645T	Transcatheter Implantation Of Coronary Sinus Reduction Device Including Vascular Access And Closure Right Heart Catheterization Venous Angiography Coronary Sinus Angiography Imaging Guidance And Supervision And Interpretation When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0646T	Transcatheter Tricuspid Valve Implantation (Ttvi)/Replacement With Prosthetic Valve Percutaneous Approach Including Right Heart Catheterization Temporary Pacemaker Insertion And Selective Right Ventricular Or Right Atrial Angiography When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0650T	Programming Device Evaluation (Remote) Of Subcutaneous Cardiac Rhythm Monitor System With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanently Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0651T	Magnetically Controlled Capsule Endoscopy Esophagus Through Stomach Including Intraprocedural Positioning Of Capsule With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0656T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0657T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0658T	Electrical Impedance Spectroscopy Of 1 Or More Skin Lesions For Automated Melanoma Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0664T	Donor Hysterectomy (Including Cold Preservation); Open From Cadaver Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

0665T	Donor Hysterectomy (Including Cold Preservation); Open From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0666T	Donor Hysterectomy (Including Cold Preservation); Laparoscopic Or Robotic From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0667T	Donor Hysterectomy (Including Cold Preservation); Recipient Uterus Allograft Transplantation From Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0668T	Backbench Standard Preparation Of Cadaver Or Living Donor Uterine Allograft Prior To Transplantation Including Dissection And Removal Of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(Ies) As Necessary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0669T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0670T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0672T	Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0692T	Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Effective 5/1/2024
0740T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set-Up And Patient Education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0741T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0743T	Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd) With Concurrent Vertebral Fracture Assessment Utilizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bmd And Classification Of Any Vertebral Fractures With Overall Fracture-Risk Assessment Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

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).	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
0767T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse Peripheral Nerve With Identification And Marking Of The Treatment Location Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization) When Performed; Each Additional Nerve (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
0773T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Initial 15 Minutes Of Intraservice Time Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0774T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
0779T	Gastrointestinal Myoelectrical Activity Study Stomach Through Colon With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0781T	Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Bilateral Mainstem Bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0782T	Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Unilateral Mainstem Bronchus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0783T	Transcutaneous Auricular Neurostimulation Set-Up Calibration And Patient Education On Use Of Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0784T	Insertion Or Replacement Of Percutaneous Electrode Array Spinal With Integrated Neurostimulator Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0785T	Revision Or Removal Of Neurostimulator Electrode Array Spinal With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0786T	Insertion Or Replacement Of Percutaneous Electrode Array Sacral With Integrated Neurostimulator Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0787T	Revision Or Removal Of Neurostimulator Electrode Array Sacral With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0788T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Spinal Cord Or Sacral Nerve 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024

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.	4/1/2024	–	Add effective 04/01/2024
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	–	Add effective 05/15/2024
0790T	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering Including Thoracoscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
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).	–	–	–
0793T	Percutaneous Transcatheter Thermal Ablation Of Nerves Innervating The Pulmonary Arteries Including Right Heart Catheterization Pulmonary Artery Angiography And All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
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.	–	–	–
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.	–	–	–

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.	_	_	_
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.	_	_	_
0799T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0800T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0801T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Dual-Chamber System (Ie Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0802T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

0803T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0804T	Programming Device Evaluation (In Person) With Iterative Adjustment Of Implantable Device To Test The Function Of Device And To Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Leadless Pacemaker System In Dual Cardiac Chambers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie Caval Valve Implantation [Cavi]); Percutaneous Femoral Vein Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0806T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie Caval Valve Implantation [Cavi]); Open Femoral Vein Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0807T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Previously Acquired Computed Tomography (Ct) Images Including Data Preparation And Transmission Quantification Of Pulmonary Tissue Ventilation Data Review Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0808T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Computed Tomography (Ct) Images Taken For The Purpose Of Pulmonary Tissue Ventilation Analysis Including Data Preparation And Transmission Quantification Of Pulmonary Tissue Ventilation Data Review Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0809T	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intraarticular implant(s), including allograft or synthetic device(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).	_	_	_
0810T	Subretinal Injection Of A Pharmacologic Agent Including Vitrectomy And 1 Or More Retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
0813T	Esophagogastroduodenoscopy Flexible Transoral With Volume Adjustment Of Intragastric Bariatric Balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024	Add effective 04/01/2024

0813T	Esophagogastroduodenoscopy Flexible Transoral With Volume Adjustment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or Receiver Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve; Subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024	Add effective 05/15/2024 Retire effective 06/30/2024
0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or Receiver Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	6/30/2024	Add effective 05/15/2024 Retire effective 06/30/2024
0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0823T	Transcatheter Insertion Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	_	Effective 5/15/2024
0824T	Transcatheter Removal Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	_	Effective 5/15/2024
0825T	Transcatheter Removal And Replacement Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	_	Effective 5/15/2024

0826T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Leadless Pacemaker System In Single-Cardiac Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	_	Effective 5/15/2024
0861T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Both Components (Battery And Transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0862T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0863T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Transmitter Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024	Add effective 04/01/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
213AA	Proc/Treat/Equip/Ins/Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213BA	Otc Drugs Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213CA	Vision/Hear/Dental Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213EA	Assit Disabled/Misc Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213FA	Corr Eye Surgery Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213GA	Premiums Non- Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213HA	Copays Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213JA	Limited Purpose Hca Non- Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213KA	Preventative Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
213LA	Long Term Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
9701A	Non-Prescription Drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

A0426	Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (Als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A0430	Ambulance Service Conventional Air Services Transport One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
A0435	Fixed 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.	_	_	_
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.	_	_	_
A0888	Noncovered Ambulance Mileage Per Mile (E. G. For Miles Traveled Beyond Closest Appropriate Facility)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A0999	Unlisted Ambulance Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
A2006	Novosorb Synpath Dermal Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2007	Restrata Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

A2008	Theragenesis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2009	Symphony Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2010	Apis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2011	Supra Sdrm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2012	Suprathel Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2013	Innovamatrix Fs Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2014	Omeza Collagen Matrix Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2015	Phoenix Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2016	Permeaderm B Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2017	Permeaderm Glove Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2018	Permeaderm C Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

A2019	Kerecis Omega3 Marigen Shield Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2020	Ac5 Advanced Wound System (Ac5)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2021	Neomatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2022	Innovaburn Or Innovamatrix Xl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2023	Innovamatrix Pd 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2024	Resolve Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2025	Miro3D Per Cubic Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A2026	Restrata Minimatrix 5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
A4100	Skin Substitute Fda Cleared As A Device Not Otherwise Specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A4335	Incontinence Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4341	Indwelling Intraurethral Drainage Device With Valve Patient Inserted Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A4342	Accessories For Patient Inserted Indwelling Intraurethral Drainage Device With Valve Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A4421	Ostomy Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

A4458	Enema Bag With Tubing Reusable	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
A4540	Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
A4540	Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
A4541	Monthly Supplies For Use Of Device Coded At E0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
A4553	Non-Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4554	Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4555	Electrode/Transducer For Use With Electrical Stimulation Device Used For Cancer Treatment Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A4560	Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	_	Add effective 1/15/2024
A4560	Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	1/14/2024	Add effective 10/15/2023 Retire effective 01/14/2024
A4575	Topical Hyperbaric Oxygen Chamber Disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A4596	Cranial Electrotherapy Stimulation (Ces) System Supplies And Accessories Per Month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

A4600	Sleeve For Intermittent Limb Compression Device Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
A4638	Replacement Battery For Patient-Owned Ear Pulse Generator Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
A4639	Replacement Pad For Infrared Heating Pad System Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A4641	Radiopharmaceutical Diagnostic Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4649	Surgical Supply; Miscellaneous	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4890	Contracts Repair And Maintenance For Hemodialysis Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4913	Miscellaneous Dialysis Supplies Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A4927	Gloves Non-Sterile Per 100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4931	Oral Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A4932	Rectal Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A5507	For Diabetics Only Not Otherwise Specified Modification (Including Fitting) Of Off-The-Shelf Depth-Inlay Shoe Or Custom-Molded Shoe Per Shoe	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6000	Non-Contact Wound Warming Wound Cover For Use With The Non-Contact Wound Warming Device And Warming Card	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A6261	Wound Filler Gel/Paste Per Fluid Ounce Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6262	Wound Filler Dry Form Per Gram Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6512	Compression Burn Garment Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6549	Gradient Compression Garment Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A7049	Expiratory Positive Airway Pressure Intranasal Resistance Valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A9150	Non-Prescription Drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

A9152	Single Vitamin/Mineral/Trace Element Oral Per Dose Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9153	Multiple Vitamins With Or Without Minerals And Trace Elements Oral Per Dose Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
A9279	Monitoring Feature/Device Stand-Alone Or Integrated Any Type Includes All Accessories Components And Electronics Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9280	Alert Or Alarm Device Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9282	Wig Any Type Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A9285	Inversion/Eversion Correction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course Of Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	1/31/2024	Retire effective 1/31/2024
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course Of Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	_	Add effective 02/1/2024
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
A9579	Injection Gadolinium-Based Magnetic Resonance Contrast Agent Not Otherwise Specified (Nos) Per Ml	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9597	Positron Emission Tomography Radiopharmaceutical Diagnostic For Tumor Identification Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9598	Positron Emission Tomography Radiopharmaceutical Diagnostic For Non-Tumor Identification Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9698	Non-Radioactive Contrast Imaging Material Not Otherwise Classified Per Study	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9699	Radiopharmaceutical Therapeutic Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

A9900	Miscellaneous Dme Supply Accessory And/Or Service Component Of Another Hcpcs Code	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A9999	Miscellaneous Dme Supply Or Accessory Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
B9998	Noc For Enteral Supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
B9999	Noc For Parenteral Supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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).	_	_	_
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.	4/1/2024	_	Add effective 04/01/2024
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.	_	_	_
C1764	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
C1778	Lead Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
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.	_	_	_
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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.	_	_	_

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.	_	_	_
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).	_	_	_
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	_	Add effective 05/15/2024
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	Add effective 02/1/2024 Retire effective 05/14/2024
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.	_	_	_
C1889	Implantable/Insertable Device Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	2/1/2024	_	Add effective 02/1/2024
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.	_	_	_
C2698	Brachytherapy Source Stranded Not Otherwise Specified Per Source	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C2699	Brachytherapy Source Non-Stranded Not Otherwise Specified Per Source	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_

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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
C9157	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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	_	Add effective 05/15/2024
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	_	Add effective 05/01/2024
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	_	Effective 8/1/2024

C9257	Injection Bevacizumab 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
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).	_	_	_
C9356	Tendon Porous Matrix Of Cross-Linked Collagen And Glycosaminoglycan Matrix (Tenoglide Tendon Protector Sheet) Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9358	Dermal Substitute Native Non-Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9360	Dermal Substitute Native Non-Denatured Collagen Neonatal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9363	Skin Substitute Integra Meshed Bilayer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9364	Porcine Implant Permacol Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9399	Unclassified Drugs Or Biologicals	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
C9734	Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
C9739	Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_

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).	_	_	_
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.	_	_	_
C9765	Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) 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.	_	_	_
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.	_	_	_
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.	_	_	_
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).	_	_	_
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.	_	_	_
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).	_	_	_
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).	_	_	_
C9774	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel (S) When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9775	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel (S) When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

C9777	Esophageal Mucosal Integrity Testing By Electrical Impedance Transoral Includes Esophagoscopy Or Esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9782	Blinded Procedure For New York Heart Association (Nyha) Class Ii Or Iii Heart Failure Or Canadian Cardiovascular Society (Ccs) Class Iii Or Iv Chronic Refractory Angina; Transcatheter Intramyocardial Transplantation Of Autologous Bone Marrow Cells (E.G. Mononuclear) Or Placebo Control Autologous Bone Marrow Harvesting And Preparation For Transplantation Left Heart Catheterization Including Ventriculography All Laboratory Services And All Imaging With Or Without Guidance (E.G. Transthoracic Echocardiography Ultrasound Fluoroscopy) Performed In An Approved Investigational Device Exemption (Ide) Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	_	Add effective 02/1/2024
C9784	Gastric Restrictive Procedure Endoscopic Sleeve Gastroplasty With Esophagogastroduodenoscopy And Intraluminal Tube Insertion If Performed Including All System And Tissue Anchoring Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9785	Endoscopic Outlet Reduction Gastric Pouch Application With Endoscopy And Intraluminal Tube Insertion If Performed Including All System And Tissue Anchoring Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9786	Echocardiography Image Post Processing For Computer Aided Detection Of Heart Failure With Preserved Ejection Fraction Including Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
C9793	3D Predictive Model Generation For Pre-Planning Of A Cardiac Procedure Using Data From Cardiac Computed Tomographic Angiography With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	_	Effective 8/1/2024
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	6/30/2024	Add effective 04/01/2024 Retire effective 06/30/2024
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
C9898	Radiolabeled Product Provided During A Hospital Inpatient Stay	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
C9899	Implanted Prosthetic Device Payable Only For Inpatients Who Do Not Have Inpatient Coverage	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

D0999	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D1705	Astrazeneca Covid-19 Vaccine Administration – First Dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D1706	Astrazeneca Covid-19 Vaccine Administration – Second Dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D1999	Unspecified Preventive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D2999	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D3999	Unspecified Endodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D4999	Unspecified Periodontal Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D5899	Unspecified Removable Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D7210	Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D7999	Unspecified Oral Surgery Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D8210	Removable Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D8999	Unspecified Orthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D9999	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E0183	Powered Pressure Reducing Underlay/Pad Alternating With Pump Includes Heavy Duty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0210	Electric Heat Pad Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

E0217	Water Circulating Heat Pad With Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0218	Fluid Circulating Cold Pad With Pump Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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).	_	_	_
E0236	Pump For Water Circulating Pad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0240	Bath/Shower Chair With Or Without Wheels Any Size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0241	Bath Tub Wall Rail Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0242	Bath Tub Rail Floor Base	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0243	Toilet Rail Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0244	Raised Toilet Seat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0247	Transfer Bench For Tub Or Toilet With Or Without Commode Opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
E0273	Bed Board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0274	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
E0300	Pediatric Crib Hospital Grade Fully Enclosed With Or Without Top Enclosure	MP Criteria: Procedure/service reviewed against 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 Plan. Not subject to pre-service review.	_	_	_

E0316	Safety Enclosure Frame/Canopy For Use With Hospital Bed Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0446	Topical Oxygen Delivery System Not Otherwise Specified Includes All Supplies And Accessories	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E0485	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Prefabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
E0486	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
E0487	Spirometer Electronic Includes All Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0490	Power Source And Control Electronics Unit For Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Controlled By Hardware Remote	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0491	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Used In Conjunction With The Power Source And Control Electronics Unit Controlled By Hardware Remote 90-Day Supply	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0492	Power Source And Control Electronics Unit For Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Controlled By Phone Application	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
E0493	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Used In Conjunction With The Power Source And Control Electronics Unit Controlled By Phone Application 90-Day Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
E0530	Electronic Positional Obstructive Sleep Apnea Treatment With Sensor Includes All Components And Accessories Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
E0616	Implantable Cardiac Event Recorder With Memory Activator And Programmer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0617	External Defibrillator With Integrated Electrocardiogram Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	_	Effective 5/15/2024
E0625	Patient Lift Bathroom Or Toilet Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

E0635	Patient Lift Electric With Seat Or Sling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0637	Combination Sit To Stand Frame/Table System Any Size Including Pediatric With Seat Lift Feature With Or Without Wheels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0638	Standing Frame/Table System One Position (E.G. Upright Supine Or Prone Stander) Any Size Including Pediatric With Or Without Wheels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0641	Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or Without Wheels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0642	Standing Frame/Table System Mobile (Dynamic Stander) Any Size Including Pediatric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0650	Pneumatic Compressor Non-Segmental Home Model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0651	Pneumatic Compressor Segmental Home Model Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0652	Pneumatic Compressor Segmental Home Model With Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0655	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0656	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0657	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0660	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0665	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0666	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0667	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0668	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

E0669	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0670	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Integrated 2 Full Legs And Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0671	Segmental Gradient Pressure Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0672	Segmental Gradient Pressure Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0673	Segmental Gradient Pressure Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0675	Pneumatic Compression Device High Pressure Rapid Inflation/Deflation Cycle For Arterial Insufficiency (Unilateral Or Bilateral System)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0676	Intermittent Limb Compression Device (Includes All Accessories) Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E0677	Non-Pneumatic Sequential Compression Garment Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0678	Non-Pneumatic Sequential Compression Garment Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
E0679	Non-Pneumatic Sequential Compression Garment Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
E0680	Non-Pneumatic Compression Controller With Sequential Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
E0681	Non-Pneumatic Compression Controller Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
E0682	Non-Pneumatic Sequential Compression Garment Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
E0691	Ultraviolet Light Therapy System Includes Bulbs/Lamps Timer And Eye Protection; Treatment Area 2 Square Feet Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

E0692	Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 4 Foot Panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0693	Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 6 Foot Panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0694	Ultraviolet Multidirectional Light Therapy System In 6 Foot Cabinet Includes Bulbs/Lamps Timer And Eye Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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	_	Add effective 05/15/2024
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	Add effective 02/15/2024 Retire effective 05/14/2024
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	_	Add effective 02/15/2024
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	_	Add effective 05/15/2024
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	Add effective 02/15/2024 Retire effective 05/14/2024
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	_	Add effective 02/15/2024
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).	_	_	_
E0744	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
E0746	Electromyography (Emg) Biofeedback Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_

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.	_	_	_
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.	_	_	_
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).	_	_	_
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).	_	_	_
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.	_	_	_
E0769	Electrical Stimulation Or Electromagnetic Wound Treatment Device Not Otherwise Classified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0770	Functional Electrical Stimulator Transcutaneous Stimulation Of Nerve And/Or Muscle Groups Any Type Complete System Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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).	_	_	_
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).	_	_	_
E0849	Traction Equipment Cervical Free-Standing Stand/Frame Pneumatic Applying Traction Force To Other Than Mandible	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0850	Traction Stand Free Standing Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

E0855	Cervical Traction Equipment Not Requiring Additional Stand Or Frame	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0856	Cervical Traction Device With Inflatable Air Bladder(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0860	Traction Equipment Overdoor Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0890	Traction Frame Attached To Footboard Pelvic Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0936	Continuous Passive Motion Exercise Device For Use Other Than Knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E0985	Wheelchair Accessory Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E0986	Manual Wheelchair Accessory Push-Rim Activated Power Assist System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1002	Wheelchair Accessory Power Seating System Tilt Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1003	Wheelchair Accessory Power Seating System Recline Only Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1004	Wheelchair Accessory Power Seating System Recline Only With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1005	Wheelchair Accessory Power Seatng System Recline Only With Power Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

E1006	Wheelchair Accessory Power Seating System Combination Tilt And Recline Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1007	Wheelchair Accessory Power Seating System Combination Tilt And Recline With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1008	Wheelchair Accessory Power Seating System Combination Tilt And Recline With Power Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1009	Wheelchair Accessory Addition To Power Seating System Mechanically Linked Leg Elevation System Including Pushrod And Leg Rest Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1010	Wheelchair Accessory Addition To Power Seating System Power Leg Elevation System Including Leg Rest Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1012	Wheelchair Accessory Addition To Power Seating System Center Mount Power Elevating Leg Rest/Platform Complete System Any Type Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1161	Manual Adult Size Wheelchair Includes Tilt In Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1229	Wheelchair Pediatric Size Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1230	Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name And Model Number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1239	Power Wheelchair Pediatric Size Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1301	Whirlpool Tub Walk-In Portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/24/2024	_	Effective 4/24/2024
E1399	Durable Medical Equipment Miscellaneous	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E1629	Tablo Hemodialysis System For The Billable Dialysis Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E1632	Wearable Artificial Kidney Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E1699	Dialysis Equipment Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

E1700	Jaw Motion Rehabilitation 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).	_	_	_
E1701	Replacement Cushions For Jaw Motion Rehabilitation System Pkg. Of 6	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E1702	Replacement Measuring Scales For Jaw Motion Rehabilitation System Pkg. Of 200	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
E2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic Fluid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
E2298	Complex Rehabilitative Power Wheelchair Accessory Power Seat Elevation System Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
E2300	Wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2301	Wheelchair Accessory Power Standing System Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2310	Power Wheelchair Accessory Electronic Connection Between Wheelchair Controller And One Power Seating System Motor Including All Related Electronics Indicator Feature Mechanical Function Selection Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2311	Power Wheelchair Accessory Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors Including All Related Electronics Indicator Feature Mechanical Function Selection Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2312	Power Wheelchair Accessory Hand Or Chin Control Interface Mini-Proportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2313	Power Wheelchair Accessory Harness For Upgrade To Expandable Controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2321	Power Wheelchair Accessory Hand Control Interface Remote Joystick Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

E2322	Power Wheelchair Accessory Hand Control Interface Multiple Mechanical Switches Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2323	Power Wheelchair Accessory Specialty Joystick Handle For Hand Control Interface Prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2324	Power Wheelchair Accessory Chin Cup For Chin Control Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2325	Power Wheelchair Accessory Sip And Puff Interface Nonproportional Including All Related Electronics Mechanical Stop Switch And Manual Swingaway Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2326	Power Wheelchair Accessory Breath Tube Kit For Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2327	Power Wheelchair Accessory Head Control Interface Mechanical Proportional Including All Related Electronics Mechanical Direction Change Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2328	Power Wheelchair Accessory Head Control Or Extremity Control Interface Electronic Proportional Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2329	Power Wheelchair Accessory Head Control Interface Contact Switch Mechanism Nonproportional Including All Related Electronics Mechanical Stop Switch Mechanical Direction Change Switch Head Array And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
E2341	Power Wheelchair Accessory Nonstandard Seat Frame Width 24-27 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2342	Power Wheelchair Accessory Nonstandard Seat Frame Depth 20 Or 21 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

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.	_	_	_
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.	_	_	_
E2373	Power Wheelchair Accessory Hand Or Chin Control Interface Compact Remote Joystick Proportional Including Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2374	Power Wheelchair Accessory Hand Or Chin Control Interface Standard Remote Joystick (Not Including Controller) Proportional Including All Related Electronics And Fixed Mounting Hardware Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2375	Power Wheelchair Accessory Non-Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2376	Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2377	Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Upgrade Provided At Initial Issue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2500	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Less Than Or Equal To 8 Minutes Recording Time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2502	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2504	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2506	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 40 Minutes Recording Time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2508	Speech Generating Device Synthesized Speech Requiring Message Formulation By Spelling And Access By Physical Contact With The Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2510	Speech Generating Device Synthesized Speech Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2511	Speech Generating Software Program For Personal Computer Or Personal Digital Assistant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E2512	Accessory For Speech Generating Device Mounting System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

E2599	Accessory For Speech Generating Device Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
E2610	Wheelchair Seat Cushion Powered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
E3000	Speech Volume Modulation System Any Type Including All Components And Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
E3000	Speech Volume Modulation System Any Type Including All Components And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	5/14/2024	Add effective 02/15/2024 Retire effective 05/14/2024
G0176	Activity Therapy Such As Music Dance Art Or Play Therapies Not For Recreation Related To The Care And Treatment Of Patient'S Disabling Mental Health Problems Per Session (45 Minutes Or More)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
G0255	Current Perception Threshold/Sensory Nerve Conduction Test (Snct) Per Limb Any Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G0276	Blinded Procedure For Lumbar Stenosis Percutaneous Image-Guided Lumbar Decompression (Pild) Or Placebo-Control Performed In An Approved Coverage With Evidence Development (Ced) Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0277	Hyperbaric Oxygen Under Pressure Full Body Chamber Per 30 Minute Interval	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
G0281	Electrical Stimulation (Unattended) To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Statsis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

G0282	Electrical Stimulation (Unattended) To One Or More Areas For Wound Care Other Than Described In G0281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G0293	Noncovered Surgical Procedure(S) Using Conscious Sedation Regional General Or Spinal Anesthesia In A Medicare Qualifying Clinical Trial Per Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0294	Noncovered Procedure(S) Using Either No Anesthesia Or Local Anesthesia Only In A Medicare Qualifying Clinical Trial Per Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G0295	Electromagnetic Therapy To One Or More Areas For Wound Care Other Than Described In G0329 Or For Other Uses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G0329	Electromagnetic Therapy To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Stasis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G0341	Percutaneous Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0342	Laparoscopy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0343	Laparotomy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0422	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0423	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session	MP Criteria: Procedure/service reviewed against 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 Collagen Scaffold Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G0460	Autologous Platelet Rich Plasma Or Other Blood-Derived Product For Non-Diabetic Chronic Wounds/Ulcers Including As Applicable Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures Administration And Dressings Per Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

G0465	Autologous Platelet Rich Plasma (Prp) Or Other Blood-Derived Product For Diabetic Chronic Wounds/Ulcers Using An Fda-Cleared Device For This Indication (Includes As Applicable Administration Dressings Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures Per Treatment)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
G2011	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G2082	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Up To 56 Mg Of Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G2083	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Greater Than 56 Mg Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
G8395	Left Ventricular Ejection Fraction (Lvef) >= 40% Or Documentation As Normal Or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8396	Left Ventricular Ejection Fraction (Lvef) Not Performed Or Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8397	Dilated Macular Or Fundus Exam Performed Including Documentation Of The	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8399	Patient With Documented Results Of A Central Dual-Energy X-Ray Absorptiometry (Dxa) Ever Being Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8400	Patient With Central Dual-Energy X-Ray Absorptiometry (Dxa) Results Not Documented Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8404	Lower Extremity Neurological Exam Performed And Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8405	Lower Extremity Neurological Exam Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8410	Footwear Evaluation Performed And Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8415	Footwear Evaluation Was Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8416	Clinician Documented That Patient Was Not An Eligible Candidate For Footwear	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8417	Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8418	Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8419	Bmi Documented Outside Normal Parameters No Follow-Up Plan Documented No Reason Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G8420	Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8421	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8427	Eligible Clinician Attests To Documenting In The Medical Record They Obtained Updated Or Reviewed The Patient'S Current Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G8428	Current List Of Medications Not Documented As Obtained Updated Or Reviewed By The Eligible Clinician Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
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.	_	_	_
G8432	Depression Screening Not Documented Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
G8450	Beta-Blocker Therapy Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
G8452	Beta-Blocker Therapy Not Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_

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.	–	–	–
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.	–	–	–
G8482	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
G8484	Influenza Immunization Was Not Administered Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9012	Other Specified Case Management Service Not Elsewhere Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
G9050	Oncology; Primary Focus Of Visit; Work-Up Evaluation Or Staging At The Time Of Cancer Diagnosis Or Recurrence (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9051	Oncology; Primary Focus Of Visit; Treatment Decision-Making After Disease Is Staged Or Restaged Discussion Of Treatment Options Supervising/Coordinating Active Cancer Directed Therapy Or Managing Consequences Of Cancer Directed Therapy (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9052	Oncology; Primary Focus Of Visit; Surveillance For Disease Recurrence For Patient Who Has Completed Definitive Cancer-Directed Therapy And Currently Lacks Evidence Of Recurrent Disease; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9053	Oncology; Primary Focus Of Visit; Expectant Management Of Patient With Evidence Of Cancer For Whom No Cancer Directed Therapy Is Being Administered Or Arranged At Present; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9054	Oncology; Primary Focus Of Visit; Supervising Coordinating Or Managing Care Of Patient With Terminal Cancer Or For Whom Other Medical Illness Prevents Further Cancer Treatment; Includes Symptom Management End-Of-Life Care Planning Management Of Palliative Therapies (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9055	Oncology; Primary Focus Of Visit; Other Unspecified Service Not Otherwise Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
G9056	Oncology; Practice Guidelines; Management Adheres To Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9057	Oncology; Practice Guidelines; Management Differs From Guidelines As A Result Of Patient Enrollment In An Institutional Review Board Approved Clinical Trial (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9058	Oncology; Practice Guidelines; Management Differs From Guidelines Because The Treating Physician Disagrees With Guideline Recommendations (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9059	Oncology; Practice Guidelines; Management Differs From Guidelines Because The Patient After Being Offered Treatment Consistent With Guidelines Has Opted For Alternative Treatment Or Management Including No Treatment (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9060	Oncology; Practice Guidelines; Management Differs From Guidelines For Reason(S) Associated With Patient Comorbid Illness Or Performance Status Not Factored Into Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9061	Oncology; Practice Guidelines; Patient'S Condition Not Addressed By Available Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9062	Oncology; Practice Guidelines; Management Differs From Guidelines For Other Reason(S) Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9063	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage I (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9064	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Ii (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

G9065	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Iii A (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9066	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Stage Iii B- Iv At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9067	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9068	Oncology; Disease Status; Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extent Of Disease Initially Established As Limited With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9069	Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extensive Stage At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9070	Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9071	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9072	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9073	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9074	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9075	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9077	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T1-T2C And Gleason 2-7 And Psa < Or Equal To 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9078	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T2 Or T3A Gleason 8-10 Or Psa > 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9079	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T3B-T4 Any N; Any T N1 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9080	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; After Initial Treatment With Rising Psa Or Failure Of Psa Decline (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9083	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9084	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N0 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9085	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 N0 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9086	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-4 N1-2 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9087	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive With Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9088	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive Without Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9089	Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9090	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-2 N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9091	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T3 N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9092	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N1-2 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9093	Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 Any N M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–

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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
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.	–	–	–
G9106	Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Post R1 Or R2 Resection With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9107	Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Unresectable At Diagnosis M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9108	Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9109	Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Initially Established As T1-T2 And N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9110	Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Initially Established As T3-4 And/Or N1-3 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9111	Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9112	Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9113	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 1) Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9114	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 2-3); Or Stage Ic (All Grades); Or Stage Ii; Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9115	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Iii-Iv; Without Evidence Of Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9116	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Evidence Of Disease Progression Or Recurrence And/Or Platinum Resistance (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9117	Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9123	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Chronic Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9124	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Accelerated Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9125	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Blast Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9126	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9128	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Smoldering Stage I (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9129	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Stage Ii Or Higher (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9130	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9131	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9132	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; Hormone-Refractory/Androgen-Independent (E.G. Rising Psa On Anti-Androgen Therapy Or Post-Orchiectomy); Clinical Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9133	Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; Hormone-Responsive; Clinical Metastases Or M1 At Diagnosis (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9134	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any Cellular Classification; Stage I Ii At Diagnosis Not Relapsed Not Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9135	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any Cellular Classification; Stage Iii Iv Not Relapsed Not Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9136	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Transformed From Original Cellular Diagnosis To A Second Cellular Classification (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9137	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any Cellular Classification; Relapsed/Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9138	Oncology; Disease Status; Non-Hodgkin'S Lymphoma Any Cellular Classification; Diagnostic Evaluation Stage Not Determined Evaluation Of Possible Relapse Or Non-Response To Therapy Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9139	Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Extent Of Disease Unknown Staging In Progress Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9140	Frontier Extended Stay Clinic Demonstration; For A Patient Stay In A Clinic Approved For The Cms Demonstration Project; The Following Measures Should Be Present: The Stay Must Be Equal To Or Greater Than 4 Hours; Weather Or Other Conditions Must Prevent Transfer Or The Case Falls Into A Category Of Monitoring And Observation Cases That Are Permitted By The Rules Of The Demonstration; There Is A Maximum Frontier Extended Stay Clinic (Fesc) Visit Of 48 Hours Except In The Case When Weather Or Other Conditions Prevent Transfer; Payment Is Made On Each Period Up To 4 Hours After The First 4 Hours	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous By Any Means Guided By The Results Of Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	–	–	–
G9978	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components: A Problem Focused History; A Problem Focused Examination; And Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology. Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Self Limited Or Minor. Typically 10 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9979	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components: An Expanded Problem Focused History;An Expanded Problem Focused Examination;Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology. Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Low To Moderate Severity. Typically 20 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9980	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components:A Detailed History;A Detailed Examination; Medical Decision Making Of Low Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate Severity. Typically 30 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9981	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components:A Comprehensive History;A Comprehensive Examination;Medical Decision Making Of Moderate Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 45 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9982	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires These 3 Key Components:A Comprehensive History;A Comprehensive Examination;Medical Decision Making Of High Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 60 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9983	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Problem Focused History;A Problem Focused Examination;Straightforward Medical Decision Making Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Self Limited Or Minor. Typically 10 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9984	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components: An Expanded Problem Focused History;An Expanded Problem Focused Examination;Medical Decision Making Of Low Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Low To Moderate Severity. Typically 15 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9985	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Detailed History; A Detailed Examination;Medical Decision Making Of Moderate Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 25 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

G9986	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Episode Of Care Which Requires At Least 2 Of The Following 3 Key Components:A Comprehensive History;A Comprehensive Examination;Medical Decision Making Of High Complexity Furnished In Real Time Using Interactive Audio And Video Technology.Counseling And Coordination Of Care With Other Physicians Other Qualified Health Care Professionals Or Agencies Are Provided Consistent With The Nature Of The Problem(S) And The Needs Of The Patient Or The Family Or Both. Usually The Presenting Problem(S) Are Of Moderate To High Severity. Typically 40 Minutes Are Spent With The Patient Or Family Or Both Via Real Time Audio And Video Intercommunications Technology.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
G9987	Bundled Payments For Care Improvement Advanced (Bpci Advanced) Model Home Visit For Patient Assessment Performed By Clinical Staff For An Individual Not Considered Homebound Including But Not Necessarily Limited To Patient Assessment Of Clinical Status Safety/Fall Prevention Functional Status/Ambulation Medication Reconciliation/Management Compliance With Orders/Plan Of Care Performance Of Activities Of Daily Living And Ensuring Beneficiary Connections To Community And Other Services; For Use Only For A Bpci Advanced Model Episode Of Care; May Not Be Billed For A 30-Day Period Covered By A Transitional Care Management Code.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
H0046	Mental Health Services Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
H0047	Alcohol And/Or Other Drug Abuse Services Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
J0129	Injection Abatacept 10 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0172	Injection Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J0174	Injection Lecanemab-Irmb 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–

J0177	Injection Aflibercept Hd 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
J0178	Injection Aflibercept 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J0179	Injection Brolucizumab-Dbll 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J0202	Injection Alemtuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0218	Injection Olipudase Alfa-Rpcp 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J0219	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0220	Injection Alglucosidase Alfa 10 Mg Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J0222	Injection Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0223	Injection Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0224	Injection Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

J0225	Injection Vutrisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J0248	Injection Remdesivir 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	_	Add effective 05/01/2024
J0256	Injection Alpha 1 Proteinase Inhibitor (Human) Not Otherwise Specified 10 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J0485	Injection Belatacept 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J0490	Injection Belimumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0491	Injection Anifrolumab-Fnia 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0517	Injection Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0565	Injection Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0567	Injection Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0584	Injection Burosumab-Twza 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J0586	Injection Abobotulinumtoxina 5 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

J0587	Injection Rimabotulinumtoxinb 100 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0588	Injection Incobotulinumtoxin A 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0589	Injection Daxibotulinumtoxina-Lanm 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	–	Add effective 05/15/2024
J0717	Injection Certolizumab Pegol 1 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	3/14/2024	retire effective 03/14/2024
J0741	Injection Cabotegravir And Rilpivirine 2Mg/3Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
J0775	Injection Collagenase Clostridium Histolyticum 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0791	Injection Crizanlizumab-Tmca 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J0881	Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J1203	Injection Cipaglucosidase Alfa-Atga 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	–	Add effective 07/15/2024

J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1302	Injection Sutimlimab-Jome 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1303	Injection Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1304	Injection Tofersen 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J1305	Injection Evinacumab-Dgnb 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1306	Injection Inclisiran 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1325	Injection Epoprostenol 0. 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1411	Injection Etranacogene Dezaparvovec-Drlb Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1412	Injection Valoctocogene Roxaparvovec-Rvox Per Ml Containing Nominal 2 X 10^13 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J1413	Injection Delandistrogene Moxeparvovec-Rokl Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J1426	Injection Casimersen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1427	Injection Viltolarsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

J1428	Injection Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1429	Injection Golodirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1551	Injection Immune Globulin (Cutaquig) 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1554	Injection Immune Globulin (Asceniv) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1566	Injection Immune Globulin Intravenous Lyophilized (E. G. Powder) Not Otherwise Specified 500 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
J1576	Injection Immune Globulin (Panzyga) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1599	Injection Immune Globulin Intravenous Non-Lyophilized (E.G. Liquid) Not Otherwise Specified 500 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
J1632	Injection Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1726	Injection Hydroxyprogesterone Caproate (Makena) 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J1729	Injection Hydroxyprogesterone Caproate Not Otherwise Specified 10 Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J1729	Injection Hydroxyprogesterone Caproate Not Otherwise Specified 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

J1746	Injection Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1747	Injection Spesolimab-Sbzo 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1823	Injection Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J1930	Injection Lanreotide 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J1951	Injection Leuprolide Acetate For Depot Suspension (Fensolvi) 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J1954	Injection Leuprolide Acetate For Depot Suspension (Cipla) 7.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2182	Injection Mepolizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2278	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	5/31/2024	Retire effective 5/31/2024
J2327	Injection Risankizumab-Rzaa Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2329	Injection Ublituximab-Xiiy 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2353	Injection Octreotide Depot Form For Intramuscular Injection 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J2354	Injection Octreotide Non-Depot Form For Subcutaneous Or Intravenous Injection 25 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024

J2356	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J2440	Injection Papaverine Hcl Up To 60 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2502	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	4/30/2024	Retire effective 4/30/2024
J2508	Injection Pegunigalsidase Alfa-Iwxj 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J2777	Injection Faricimab-Svoa 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2778	Injection Ranibizumab 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2779	Injection Ranibizumab Via Intravitreal Implant (Susvimo) 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J2782	Injection Avacincaptad Pegol 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	_	Add effective 07/15/2024
J2796	Injection Romiplostim 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J3032	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J3111	Injection Romosozumab-Aqqg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J3121	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

J3145	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3241	Injection Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3245	Injection Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	5/31/2024	Retire effective 5/31/2024
J3285	Injection Treprostinil 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3299	Injection Triamcinolone Acetonide (Xipere) 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J3380	Injection Vedolizumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3396	Injection Verteporfin 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J3398	Injection Voretigene Neparvovec-Rzyl 1 Billion Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3399	Injection Onasemnogene Abeparvovec-Xioi Per Treatment Up To 5X10^15 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
J3401	Beremagene Geperpavec-Svdt For Topical Administration Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes Per 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024

J3490	Unclassified Drugs	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
J3520	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J3570	Laetrile Amygdalin Vitamin B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
J3591	Unclassified Drug Or Biological Used For Esrd On Dialysis	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7177	Injection Human Fibrinogen Concentrate (Fibryga) 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J7178	Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J7183	Injection Von Willebrand Factor Complex (Human) Wilate 1 I.U. Vwf:Rco	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
J7192	Factor Viii (Antihemophilic Factor Recombinant) Per I.U. Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7195	Injection Factor Ix (Antihemophilic Factor Recombinant) Per Iu Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7199	Hemophilia Clotting Factor Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7309	Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J7316	Injection Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J7402	Mometasone Furoate Sinus Implant (Sinuva) 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J7599	Immunosuppressive Drug Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7604	Acetylcysteine Inhalation Solution Compounded Product Administered Through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

J7607	Levalbuterol Inhalation Solution Compounded Product Administered Through Dme Concentrated Form 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7609	Albuterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
J7638	Dexamethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7640	Formoterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form 12 Micrograms	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7641	Flunisolide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7642	Glycopyrrolate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7643	Glycopyrrolate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7645	Ipratropium Bromide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7647	Isoetharine Hcl Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7650	Isoetharine Hcl Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

J7657	Isoproterenol Hcl Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7660	Isoproterenol Hcl Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7667	Metaproterenol Sulfate Inhalation Solution Compounded Product Concentrated Form Per 10 Milligrams	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7670	Metaproterenol Sulfate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per 10 Milligrams	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
J7680	Terbutaline Sulfate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
J7683	Triamcinolone Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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).	_	_	_
J7699	Noc Drugs Inhalation Solution Administered Through Dme	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7799	Noc Drugs Other Than Inhalation Drugs Administered Through Dme	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J7999	Compounded Drug Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

J8498	Antiemetic Drug Rectal/Suppository Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J8499	Prescription Drug Oral Non Chemotherapeutic Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J8597	Antiemetic Drug Oral Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J8999	Prescription Drug Oral Chemotherapeutic Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J9020	Injection Asparaginase Not Otherwise Specified 10 000 Units	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
J9029	Intravesical Instillation Nadofaragene Firadenovec-Vncg Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J9037	Injection Belantamab Mafodontin-Blmf 0.5 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	_	Add effective 04/01/2024
J9057	Injection Copanlisib 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	_	Add effective 04/01/2024
J9285	Injection Olaratumab 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
J9313	Injection Moxetumomab Pasudotox-Tdfk 0.01 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	_	Add effective 04/01/2024
J9332	Injection Efgartigimod Alfa-Fcab 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
J9333	Injection Rozanolixizumab-Noli 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J9334	Injection Efgartigimod Alfa 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
J9376	Injection Pozelimab-Bbfg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2024	_	Add effective 04/01/2024
J9381	Injection Teplizumab-Mzwv 5 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
J9600	Injection Porfimer Sodium 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

J9999	Not Otherwise Classified Antineoplastic Drugs	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	_	_	_
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0011	Standard - Weight Frame Motorized/Power Wheelchair With Programmable Control Parameters For Speed Adjustment Tremor Dampening Acceleration Control And Braking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0012	Lightweight Portable Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0014	Other Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0053	Elevating Footrests Articulating (Telescoping) Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0065	Spoke Protectors Each	MP Criteria: Procedure/service reviewed against 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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0455	Infusion Pump Used For Uninterrupted Parenteral Administration Of Medication (E. G. Epoprostenol Or Treprostinol)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0800	Power Operated Vehicle Group 1 Standard Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0801	Power Operated Vehicle Group 1 Heavy Duty Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0802	Power Operated Vehicle Group 1 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

K0806	Power Operated Vehicle Group 2 Standard Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0807	Power Operated Vehicle Group 2 Heavy Duty Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0808	Power Operated Vehicle Group 2 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0812	Power Operated Vehicle Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0813	Power Wheelchair Group 1 Standard Portable Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0814	Power Wheelchair Group 1 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0815	Power Wheelchair Group 1 Standard Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0816	Power Wheelchair Group 1 Standard Captains Chair Patient Weight Capactiy Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0820	Power Wheelchair Group 2 Standard Portable Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0821	Power Wheelchair Group 2 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0822	Power Wheelchair Group 2 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0823	Power Wheelchair Group 2 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0824	Power Wheelchair Group 2 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0825	Power Wheelchair Group 2 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

K0826	Power Wheelchair Group 2 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0827	Power Wheelchair Group 2 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0828	Power Wheelchair Group 2 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0829	Power Wheelchair Group 2 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0830	Power Wheelchair Group 2 Standard Seat Elevator Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0831	Power Wheelchair Group 2 Standard Seat Elevator Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0835	Power Wheelchair Group 2 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0836	Power Wheelchair Group 2 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0837	Power Wheelchair Group 2 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0838	Power Wheelchair Group 2 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0839	Power Wheelchair Group 2 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0840	Power Wheelchair Group 2 Extra Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0841	Power Wheelchair Group 2 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0842	Power Wheelchair Group 2 Standard Multiple Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0843	Power Wheelchair Group 2 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0848	Power Wheelchair Group 3 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

K0849	Power Wheelchair Group 3 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0850	Power Wheelchair Group 3 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0851	Power Wheelchair Group 3 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0852	Power Wheelchair Group 3 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0853	Power Wheelchair Group 3 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0854	Power Wheelchair Group 3 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0855	Power Wheelchair Group 3 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0856	Power Wheelchair Group 3 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0857	Power Wheelchair Group 3 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0858	Power Wheelchair Group 3 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0859	Power Wheelchair Group 3 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0860	Power Wheelchair Group 3 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0861	Power Wheelchair Group 3 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0862	Power Wheelchair Group 3 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0863	Power Wheelchair Group 3 Very Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0864	Power Wheelchair Group 3 Extra Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

K0868	Power Wheelchair Group 4 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0869	Power Wheelchair Group 4 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0870	Power Wheelchair Group 4 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0871	Power Wheelchair Group 4 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0877	Power Wheelchair Group 4 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0878	Power Wheelchair Group 4 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0879	Power Wheelchair Group 4 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0880	Power Wheelchair Group 4 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0884	Power Wheelchair Group 4 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0885	Power Wheelchair Group 4 Standard Multiple Power Option Captains Chair Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0886	Power Wheelchair Group 4 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0890	Power Wheelchair Group 5 Pediatric Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0891	Power Wheelchair Group 5 Pediatric Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K0898	Power Wheelchair Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
K0899	Power Mobile Device; No Dme Pdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

K1004	Low Frequency Ultrasonic Diathermy Treatment Device For Home Use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
K1007	Bilateral Hip Knee Ankle Foot Device Powered Includes Pelvic Component Single Or Double Upright(S) Knee Joints Any Type With Or Without Ankle Joints Any Type Includes All Components And Accessories Motors Microprocessors Sensors	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
K1016	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.	10/15/2023	_	_
K1017	Monthly supplies for use of device coded at k1016	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K1027	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Without Fixed Mechanical Hinge Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
K1030	External Recharging System For Battery (Internal) For Use With Implanted Cardiac Contractility Modulation Generator Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
K1036	Supplies And Accessories (E.G. Transducer) For Low Frequency Ultrasonic Diathermy Treatment Device Per Month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
L0999	Addition To Spinal Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L1320	Thoracic Pectus Carinatum Orthosis Sternal Compression Rigid Circumferential Frame With Anterior And Posterior Rigid Pads Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
L1499	Spinal Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L1844	Knee Orthosis Single Upright Thigh And Calf With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric) Medial-Lateral And Rotation Control With Or Without Varus/Valgus Adjustment Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L2999	Lower Extremity Orthoses Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L3040	Foot Arch Support Removable Premolded Longitudinal Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3050	Foot Arch Support Removable Premolded Metatarsal Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
L3060	Foot Arch Support Removable Premolded Longitudinal/ Metatarsal Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

L3649	Orthopedic Shoe Modification Addition Or Transfer Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L3999	Upper Limb Orthosis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L5841	Addition Endoskeletal Knee-Shin System Polycentric Pneumatic Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024
L5857	Addition To Lower Extremity Prosthesis Endoskeletal Knee-Shin System Microprocessor Control Feature Swing Phase Only Includes Electronic Sensor(S) Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L5973	Endoskeletal Ankle Foot System Microprocessor Controlled Feature Dorsiflexion And/Or Plantar Flexion Control Includes Power Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L5991	Addition To Lower Extremity Prostheses Osseointegrated External Prosthetic Connector	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
L5999	Lower Extremity Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L6026	Transcarpal/Metacarpal Or Partial Hand Disarticulation Prosthesis External Power Self-Suspended Inner Socket With Removable Forearm Section Electrodes And Cables Two Batteries Charger Myoelectric Control Of Terminal Device Excludes Terminal Device(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6611	Addition To Upper Extremity Prosthesis External Powered Additional Switch Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6880	Electric Hand Switch Or Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6920	Wrist Disarticulation External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6925	Wrist Disarticulation External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6930	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6935	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

L6940	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6945	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6950	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6955	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6960	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6965	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6970	Interscapular-Thoracic External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L6975	Interscapular-Thoracic External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L7008	Electric Hand Switch Or Myoelectric Controlled Pediatric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L7009	Electric Hook Switch Or Myoelectric Controlled Adult	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

L7040	Prehensile Actuator Switch Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
L7364	Twelve Volt Battery Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L7366	Battery Charger Twelve Volt Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L7499	Upper Extremity Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L8039	Breast Prosthesis Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L8048	Unspecified Maxillofacial Prosthesis By Report Provided By A Non-Physician	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L8499	Unlisted Procedure For Miscellaneous Prosthetic Services	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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	_	Add effective 05/15/2024

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.	_	_	_
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).	_	_	_
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.	_	_	_
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).	_	_	_
L8612	Aqueous Shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8614	Cochlear Device Includes All Internal And External Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8615	Headset/Headpiece For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8616	Microphone For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8617	Transmitting Coil For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8618	Transmitter Cable For Use With Cochlear Implant Device Or Auditory Osseointegrated Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8619	Cochlear Implant External Speech Processor And Controller Integrated System Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_

L8621	Zinc Air Battery For Use With Cochlear Implant Device And Auditory Osseointegrated Sound Processors Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8622	Alkaline Battery For Use With Cochlear Implant Device Any Size Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8623	Lithium Ion Battery For Use With Cochlear Implant Device Speech Processor Other Than Ear Level Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8624	Lithium Ion Battery For Use With Cochlear Implant Or Auditory Osseointegrated Device Speech Processor Ear Level Replacement Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8627	Cochlear Implant External Speech Processor Component Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8628	Cochlear Implant External Controller Component Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8629	Transmitting Coil And Cable Integrated For Use With Cochlear Implant Device Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
L8678	Electrical Stimulator Supplies (External) For Use With Implantable Neurostimulator Per Month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8679	Implantable Neurostimulator Pulse Generator Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8680	Implantable Neurostimulator Electrode Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8681	Patient Programmer (External) For Use With Implantable Programmable Neurostimulator Pulse Generator Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

L8682	Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8683	Radiofrequency Transmitter (External) For Use With Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8685	Implantable Neurostimulator Pulse Generator Single Array Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8686	Implantable Neurostimulator Pulse Generator Single Array Non-Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8687	Implantable Neurostimulator Pulse Generator Dual Array Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8688	Implantable Neurostimulator Pulse Generator Dual Array Non-Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8689	External Recharging System For Battery (Internal) For Use With Implantable Neurostimulator Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8690	Auditory Osseointegrated Device Includes All Internal And External Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8691	Auditory Osseointegrated Device External Sound Processor Excludes Transducer/Actuator Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8693	Auditory Osseointegrated Device Abutment Any Length Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
L8695	External Recharging System For Battery (External) For Use With Implantable Neurostimulator Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
L8699	Prosthetic Implant Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
L8701	Powered Upper Extremity Range Of Motion Assist Device Elbow Wrist Hand With Single Or Double Upright(S) Includes Microprocessor Sensors All Components And Accessories Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

L8702	Powered Upper Extremity Range Of Motion Assist Device Elbow Wrist Hand Finger Single Or Double Upright(S) Includes Microprocessor Sensors All Components And Accessories Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0240	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0241	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0243	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0244	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0245	Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
M0246	Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider Based To The Hospital During The Covid 19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
P2031	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
P9020	Platelet Rich Plasma Each Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

P9099	Blood Component Or Product Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q0240	Injection Casirivimab And Imdevimab 600 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q0243	Injection Casirivimab And Imdevimab 2400 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q0244	Injection Casirivimab And Imdevimab 1200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q0245	Injection Bamlanivimab And Etesevimab 2100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q0507	Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist Device	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q0508	Miscellaneous Supply Or Accessory For Use With An Implanted Ventricular Assist Device	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q0509	Miscellaneous Supply Or Accessory For Use With Any Implanted Ventricular Assist Device For Which Payment Was Not Made Under Medicare Part A	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q0510	Pharmacy Supply Fee For Initial Immunosuppressive Drug(S) First Month Following Transplant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0511	Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic Or Immunosuppressive Drug(S); For The First Prescription In A 30-Day Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q0512	Pharmacy Supply Fee For Oral Anti-Cancer Oral Anti-Emetic Or Immunosuppressive Drug(S); For A Subsequent Prescription In A 30-Day Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
Q2026	Injection Radiesse 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q2028	Injection Sculptra 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q2039	Influenza Virus Vaccine Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

Q2041	Axicabtagene Ciloleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q2042	Tisagenlecleucel Up To 600 Million Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q2049	Injection Doxorubicin Hydrochloride Liposomal Imported Lipodox 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	–	Add effective 04/01/2024
Q2050	Injection Doxorubicin Hydrochloride Liposomal Not Otherwise Specified 10Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	–	–	–
Q2052	Services Supplies And Accessories Used In The Home For The Administration Of Intravenous Immune Globulin (Ivig)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–
Q2053	Brexucabtagene Autoleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q2054	Lisocabtagene Maraleucel Up To 110 Million Autologous Anti-Cd19 Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q2055	Idecabtagene Vicleucel Up To 460 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q2056	Ciltacabtagene Autoleucel Up To 100 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q4050	Cast Supplies For Unlisted Types And Materials Of Casts	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q4051	Splint Supplies Miscellaneous (Includes Thermoplastics Strapping Fasteners Padding And Other Supplies)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–

Q4082	Drug Or Biological Not Otherwise Classified Part B Drug Competitive Acquisition Program (Cap)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q4100	Skin Substitute Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
Q4101	Apligraf Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4102	Oasis Wound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4104	Integra Bilayer Matrix Wound Dressing (Bmwd) Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 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 Regeneration Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4106	Dermagraft Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4107	Graftjacket Per Square Centimeter	MP Criteria: Procedure/service reviewed against 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 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4111	Gammagraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4112	Cymetra Injectable 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4113	Graftjacket Xpress Injectable 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	_
Q4115	Alloskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4116	Alloderm Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4117	Hyalomatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4118	Matristem Micromatrix 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4121	Theraskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4122	Dermacell Dermacell Awm Or Dermacell Awm Porous Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4125	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4126	Memoderm Dermaspan Tranzgraft Or Integuply Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4127	Talymed Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4128	Flex Hd Or Allopatch Hd Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4130	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4132	Grafix Core And Grafixpl Core Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4133	Grafix Prime Grafixpl Prime Stravix And Stravixpl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4134	Hmatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4135	Mediskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4136	Ez-Derm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4137	Amnioexcel Amnioexcel Plus Or Biodexcel Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4138	Biodfence Dryflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4139	Amniomatrix Or Biodmatrix Injectable 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4140	Biodfence Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4141	Alloskin Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4142	Xcm Biologic Tissue Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4143	Repriza Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4145	Epifix Injectable 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4146	Tensix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4147	Architect Architect Px Or Architect Fx Extracellular Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4148	Neox Cord 1K Neox Cord Rt Or Clarix Cord 1K Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4150	Allowrap Ds Or Dry Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4151	Amnioband Or Guardian Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4152	Dermapure Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4153	Dermavest And Plurivest Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4154	Biovance Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4155	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4156	Neox 100 Or Clarix 100 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4157	Revitalon Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4158	Kerecis Omega3 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4159	Affinity Per Square Centimeter	MP Criteria: Procedure/service reviewed against 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 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 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 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4164	Helicoll Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4165	Keramatrix Or Kerasorb Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4166	Cytal Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4167	Truskin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4168	Amnioband 1 Mg	MP Criteria: Procedure/service reviewed against 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4170	Cygnus Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4171	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4173	Palingen Or Palingen Xplus Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4174	Palingen Or Promatrx 0.36 Mg Per 0.25 Cc	EIU: Procedure/service not reimbursed by the Plan. Not 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 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4178	Floweramniopatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4179	Flowerderm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4180	Revita Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4181	Amnio Wound Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4182	Transcyte Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4183	Surgigraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4184	Cellesta Or Cellesta Duo Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 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	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4186	Epifix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4187	Epicord Per Square Centimeter	MP Criteria: Procedure/service reviewed against 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4189	Artacent Ac 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4190	Artacent Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4191	Restorigin Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 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 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 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4195	Puraply Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not 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 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 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 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 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 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 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4203	Derma-Gide Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4204	Xwrap Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service 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 subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4206	Fluid Flow Or Fluid Gf 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4208	Novafix Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4209	Surgraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4210	Axolotl Graft Or Axolotl Dualgraft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4211	Amnion Bio Or Axobiomembrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4212	Allogen Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4213	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not 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 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 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 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 Biowound Xplus Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4218	Surgicord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4219	Surgigraft-Dual Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4220	Bellacell Hd Or Surederm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4221	Amniowrap2 Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4222	Progenamatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4224	Human Health Factor 10 Amniotic Patch (Hhf10-P) Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4225	Amniobind Or Dermabind Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4227	Amniocore Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4229	Cogenex Amniotic Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4230	Cogenex Flowable Amnion Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4231	Corplex P Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4232	Corplex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4233	Surfactor Or Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4234	Xcellerate Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4235	Amniorepair Or Altiply Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4236	Carepatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4237	Cryo-Cord Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4238	Derm-Maxx Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4239	Amnio-Maxx Or Amnio-Maxx Lite Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4240	Corecyte For Topical Use Only Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4241	Polycyte For Topical Use Only Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4242	Amniocyte Plus Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	_	_
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4246	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4247	Amniotext Patch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4248	Dermacyte Amniotic Membrane Allograft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4249	Amniply For Topical Use Only Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4250	Amnioamp-Mp Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4251	Vim Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4252	Vendaje Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4253	Zenith Amniotic Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4254	Novafix Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4255	Reguard For Topical Use Only Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4256	Mlg-Complete Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4257	Relese Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4258	Enverse Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4259	Celera Dual Layer Or Celera Dual Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4260	Signature Apatch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4261	Tag Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4262	Dual Layer Impax Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4263	Surgraft Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4264	Cocoon Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4265	Neostim Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4266	Neostim Membrane Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4267	Neostim Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4268	Surgraft Ft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4269	Surgraft Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4270	Complete Sl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4271	Complete Ft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4272	Esano A Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4273	Esano Aaa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4274	Esano Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4275	Esano Aca Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4276	Orion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4277	Woundplus Membrane Or E-Graft Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4278	Epieffect Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4279	Vendaje Ac Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4279	Vendaje Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4280	Xcell Amnio Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4281	Barrera Sl Or Barrera Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

Q4282	Cygnus Dual Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4283	Biovance Tri-Layer Or Biovance 3L Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
Q4284	Dermabind Sl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4285	Nudyn Dl Or Nudyn Dl Mesh Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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).	_	_	_
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	Add effective 03/15/2024 Retire effecitve 06/30/2024
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	_	Add effective 07/01/2024
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	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4288	Dermabind Ch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
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	Add effective 03/15/2024 Retire effecitve 06/30/2024
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	_	Add effective 07/01/2024
Q4290	Membrane Wrap-Hydro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024

Q4290	Membrane Wrap-Hydro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4291	Lamellas Xt Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4291	Lamellas Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4292	Lamellas Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4292	Lamellas Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4293	Acesso Dl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4293	Acesso Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4294	Amnio Quad-Core Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4294	Amnio Quad-Core Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4295	Amnio Tri-Core Amniotic Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4295	Amnio Tri-Core Amniotic Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024

Q4296	Rebound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4296	Rebound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4297	Emerge Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4297	Emerge Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4298	Amnicore Pro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4298	Amnicore Pro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4299	Amnicore Pro+ Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4299	Amnicore Pro+ Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4300	Acesso Tl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4300	Acesso Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4301	Activate Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024

Q4301	Activate Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4302	Complete Aca Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4302	Complete Aca Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4303	Complete Aa Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effecitve 06/30/2024
Q4303	Complete Aa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4304	Grafix Plus Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	_	Add effective 03/15/2024
Q4305	American Amnion Ac Tri-Layer Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4306	American Amnion Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4307	American Amnion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4308	Sanopellis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4309	Via Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024

Q4310	Procenta Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	–	Add effective 04/01/2024
Q5009	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	–	–	–
Q5103	Injection Infliximab-Dyyb Biosimilar (Inflectra) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q5104	Injection Infliximab-Abda Biosimilar (Renflexis) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q5106	Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-Esrd Use) 1000 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q5109	Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	–	–	–
Q5124	Injection Ranibizumab-Nuna Biosimilar (Byooviz) 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q5128	Injection Ranibizumab-Eqrn (Cimerli) Biosimilar 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
Q5133	Injection Tocilizumab-Bavi (Tofidence) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	–	Effective 8/1/2024
Q5134	Injection Natalizumab-Sztn (Tyruko) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	–	Add effective 07/01/2024
S0013	Esketamine Nasal Spray 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	–	–	–
S0117	Tretinoin Topical 5 Grams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–

S0142	Colistimethate Sodium Inhalation Solution Administered Through Dme Concentrated Form Per Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0157	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
S0197	Prenatal Vitamins 30-Day Supply	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0310	Hospitalist Services (List Separately In Addition To Code For Appropriate Evaluation And Management Service)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0320	Telephone Calls By A Registered Nurse To A Disease Management Program Member For Monitoring Purposes; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0590	Integral Lens Service Miscellaneous Services Reported Separately	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S0596	Phakic Intraocular Lens For Correction Of Refractive Error	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	_	Add effective 02/15/2024
S0622	Physical Exam For College New Or Established Patient (List Separately In Addition To Appropriate Evaluation And Management Code)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S0800	Laser In Situ Keratomileusis (Lasik)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S0810	Photorefractive Keratectomy (Prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S1001	Deluxe Item Patient Aware (List In Addition To Code For Basic Item)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S1002	Customized Item (List In Addition To Code For Basic Item)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S1091	Stent Non-Coronary Temporary With Delivery System (Propel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2083	Adjustment Of Gastric Band Diameter Via Subcutaneous Port By Injection Or Aspiration Of Saline	MP Criteria: Procedure/service reviewed against 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 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 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 Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

S2120	Low Density Lipoprotein (Ldl) Apheresis Using Heparin-Induced Extracorporeal Ldl Precipitation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
S2140	Cord Blood Harvesting For Transplantation Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2142	Cord Blood-Derived Stem-Cell Transplantation Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2150	Bone Marrow Or Blood-Derived Stem Cells (Peripheral Or Umbilical) Allogeneic Or Autologous Harvesting Transplantation And Related Complications; Including: Pheresis And Cell Preparation/Storage; Marrow Ablative Therapy; Drugs Supplies Hospitalization With Outpatient Follow-Up; Medical/Surgical Diagnostic Emergency And Rehabilitative Services; And The Number Of Days Of Pre-And Post-Transplant Care In The Global Definition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2230	Implantation Of Magnetic Component Of Semi-Implantable Hearing Device On Ossicles In Middle Ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2235	Implantation Of Auditory Brain Stem Implant	MP Criteria: Procedure/service reviewed against 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 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 Occlusion Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2401	Repair Urinary Tract Obstruction In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2402	Repair Congenital Cystic Adenomatoid Malformation In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2403	Repair Extralobar Pulmonary Sequestration In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2404	Repair Myelomeningocele In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

S2405	Repair Of Sacrococcygeal Teratoma In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2409	Repair Congenital Malformation Of Fetus Procedure Performed In Utero Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S2409	Repair Congenital Malformation Of Fetus Procedure Performed In Utero Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2411	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin Transfusion Syndrome	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S2900	Surgical Techniques Requiring Use Of Robotic Surgical 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.	_	_	_
S3600	Stat Laboratory Request (Situations Other Than S3601)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S3601	Emergency Stat Laboratory Charge For Patient Who Is Homebound Or Residing In A Nursing Facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S3650	Saliva Test Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S3652	Saliva Test Hormone Level; To Assess Preterm Labor Risk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S3900	Surface Electromyography (Emg)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S4015	Complete In Vitro Fertilization Cycle Not Otherwise Specified Case Rate	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S4023	Donor Egg Cycle Incomplete Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4025	Donor Services For In Vitro Fertilization (Sperm Or Embryo) Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4026	Procurement Of Donor Sperm From Sperm Bank	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4027	Storage Of Previously Frozen Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4030	Sperm Procurement And Cryopreservation Services; Initial Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_

S4031	Sperm Procurement And Cryopreservation Services; Subsequent Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4040	Monitoring And Storage Of Cryopreserved Embryos Per 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S4990	Nicotine Patches Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4991	Nicotine Patches Non-Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S4995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5035	Home Infusion Therapy Routine Service Of Infusion Device (E. G. Pump Maintenance)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5036	Home Infusion Therapy Repair Of Infusion Device (E. G. Pump Repair)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5100	Day Care Services Adult; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5101	Day Care Services Adult; Per Half Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5102	Day Care Services Adult; Per Diem	Non Covered: Procedure/service not covered by the 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 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 Plan. Not subject to pre-service review.	_	_	_
S5109	Home Care Training To Home Care Client Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5110	Home Care Training Family; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5111	Home Care Training Family; Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5115	Home Care Training Non-Family; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5116	Home Care Training Non-Family; Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5120	Chore Services; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5121	Chore Services; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5125	Attendant Care Services; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5126	Attendant Care Services; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

S5130	Homemaker Service Nos; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S5131	Homemaker Service Nos; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S5135	Companion Care Adult (E. G. Iadl/Adl); Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5136	Companion Care Adult (E. G. Iadl/Adl); Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5140	Foster Care Adult; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5141	Foster Care Adult; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5145	Foster Care Therapeutic Child; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5146	Foster Care Therapeutic Child; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5150	Unskilled Respite Care Not Hospice; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5151	Unskilled Respite Care Not Hospice; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5160	Emergency Response System; Installation And Testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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.	_	_	_
S5162	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5165	Home Modifications; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5170	Home Delivered Meals Including Preparation; Per Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5175	Laundry Service External Professional; Per Order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5181	Home Health Respiratory Therapy Nos Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
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.	_	_	_
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

S5497	Home Infusion Therapy Catheter Care / Maintenance Not Otherwise Classified; Includes Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
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	_	Add effective 03/01/2024
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).	_	_	_
S8131	Interferential Current Stimulator 4 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S8189	Tracheostomy Supply Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S8270	Enuresis Alarm Using Auditory Buzzer And/Or Vibration Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S8301	Infection Control Supplies Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S8460	Camisole Post-Mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S8930	Electrical Stimulation Of Auricular Acupuncture Points; Each 15 Minutes Of Personal One-On-One Contact With The Patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S8940	Equestrian/Hippotherapy Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S8948	Application Of A Modality (Requiring Constant Provider Attendance) To One Or More Areas; Low-Level Laser; Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S8990	Physical Or Manipulative Therapy Performed For Maintenance Rather Than Restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9001	Home Uterine Monitor With Or Without Associated Nursing Services	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S9002	Intra-Vaginal Motion Sensor System Provides Biofeedback For Pelvic Floor Muscle Rehabilitation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	_	Add effective 04/01/2024

S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S9090	Vertebral Axial Decompression Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S9117	Back School Per Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S9125	Respite Care In The Home Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9335	Home Therapy Hemodialysis; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Services Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S9379	Home Infusion Therapy Infusion Therapy Not Otherwise Classified; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9381	Delivery Or Service To High Risk Areas Requiring Escort Or Extra Protection Per Visit	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
S9437	Childbirth Refresher Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9438	Cesarean Birth Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the 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 Plan. Not subject to pre-service review.	_	_	_
S9442	Birthing Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9444	Parenting Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9445	Patient Education Not Otherwise Classified Non-Physician Provider Individual Per Session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9446	Patient Education Not Otherwise Classified Non-Physician Provider Group Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9447	Infant Safety (Including Cpr) Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9449	Weight Management Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

S9451	Exercise Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9454	Stress Management Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9472	Cardiac Rehabilitation Program Non-Physician Provider Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S9482	Family Stabilization Services Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9542	Home Injectable Therapy Not Otherwise Classified Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9558	Home Injectable Therapy; Growth Hormone Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S9562	Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
S9810	Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9900	Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9970	Health Club Membership Annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9975	Transplant Related Lodging Meals And Transportation Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9976	Lodging Per Diem Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9977	Meals Per Diem Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S9981	Medical Records Copying Fee Administrative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_

S9982	Medical Records Copying Fee Per Page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9986	Not Medically Necessary Service (Patient Is Aware That Service Not Medically Necessary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9988	Services Provided As Part Of A Phase I Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9990	Services Provided As Part Of A Phase Ii Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9991	Services Provided As Part Of A Phase Iii Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9992	Transportation Costs To And From Trial Location And Local Transportation Costs (E. G. Fares For Taxicab Or Bus) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9994	Lodging Costs (E. G. Hotel Charges) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9996	Meals For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S9999	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
T1014	Telehealth Transmission Per Minute Professional Services Bill Separately	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
T1505	Electronic Medication Compliance Management Device Includes All Components And Accessories Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T1999	Miscellaneous Therapeutic Items And Supplies Retail Purchases Not Otherwise Classified; Identify Product In Remarks	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2012	Habilitation Educational; Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2013	Habilitation Educational Waiver; Per Hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2014	Habilitation Prevocational Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2015	Habilitation Prevocational Waiver; Per Hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2016	Habilitation Residential Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2017	Habilitation Residential Waiver; 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2018	Habilitation Supported Employment Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2019	Habilitation Supported Employment Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2020	Day Habilitation Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

T2021	Day Habilitation Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2024	Service Assessment/Plan Of Care Development Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2025	Waiver Services; Not Otherwise Specified (Nos)	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2026	Specialized Childcare Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2027	Specialized Childcare Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2028	Specialized Supply Not Otherwise Specified Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2029	Specialized Medical Equipment Not Otherwise Specified Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2030	Assisted Living Waiver; Per Month	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2031	Assisted Living; Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2032	Residential Care Not Otherwise Specified (Nos) Waiver; Per Month	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2033	Residential Care Not Otherwise Specified (Nos) Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2034	Crisis Intervention Waiver; Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2035	Utility Services To Support Medical Equipment And Assistive Technology/Devices Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2036	Therapeutic Camping Overnight Waiver; Each Session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2037	Therapeutic Camping Day Waiver; Each Session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2038	Community Transition Waiver; Per Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2039	Vehicle Modifications Waiver; Per Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2040	Financial Management Self-Directed Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2041	Supports Brokerage Self-Directed Waiver; Per 15 Minutes	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
T2101	Human Breast Milk Processing Storage And Distribution Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
T5999	Supply Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V2025	Deluxe Frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V2199	Not Otherwise Classified Single Vision Lens	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_

V2599	Contact Lens Other Type	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V2629	Prosthetic Eye Other Type	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V2744	Tint Photochromatic Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
V2787	Astigmatism Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
V2788	Presbyopia Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
V2799	Vision Item Or Service Miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5090	Dispensing Fee Unspecified Hearing Aid	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5095	Semi-Implantable Middle Ear Hearing Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
V5267	Hearing Aid Or Assistive Listening Device/Supplies/Accessories Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5274	Assistive Listening Device Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5287	Assistive Listening Device Personal Fm/Dm Receiver Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5298	Hearing Aid Not Otherwise Classified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5299	Hearing Service Miscellaneous	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
V5362	Speech Screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	_	_	_
V5363	Language Screening	MP Criteria: Procedure/service reviewed against 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 Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed; Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	_	Add effective 06/01/2024

50541	Laparoscopy Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	_	Add effective 06/01/2024
50542	Laparoscopy Surgical; Ablation Of Renal Mass Lesion(S) Including Intraoperative Ultrasound Guidance And Monitoring When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	_	Add effective 06/01/2024
0858T	Externally Applied Transcranial Magnetic Stimulation With Concomitant Measurement Of Evoked Cortical Potentials With Automated Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	_	Add effective 06/01/2024

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

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

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

BCBSNM makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Carelon Medical Benefits Management. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Blue Cross and Blue Shield of New Mexico, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association