BlueCross BlueShield of Montana

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

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

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

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

Utilization Management Process

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

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (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
640	Anesthesia For Manipulation Of The Spine Or For Closed Procedures On The Cervical, Thoracic Or Lumbar Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

797	Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure For Morbid Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
11950	Subcutaneous Injection Of Filling Material (Eg, Collagen); 1 Cc Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11951	Subcutaneous Injection Of Filling Material (Eg, Collagen); 1.1 To 5.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11952	Subcutaneous Injection Of Filling Material (Eg, Collagen); 5.1 To 10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11954	Subcutaneous Injection Of Filling Material (Eg, Collagen); Over 10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11970	Replacement Of Tissue Expander With Permanent Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11971	Removal Of Tissue Expander Without Insertion Of Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11980	Subcutaneous Hormone Pellet Implantation (Implantation Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
11981	Insertion, Drug-Delivery Implant (Ie, Bioresorbable, Biodegradable, Non-Biodegradable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/12/2015	12/31/2999
11982	Removal, Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/12/2015	12/31/2999
11983	Removal With Reinsertion, Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/12/2015	12/31/2999
15271	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15272	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999

15273	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area, Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15274	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15275	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15276	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15277	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area, Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15278	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15758	Free Fascial Flap With Microvascular Anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2015	12/31/2999
15769	Grafting Of Autologous Soft Tissue, Other, Harvested By Direct Excision (Eg, Fat, Dermis, Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
15771	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk, Breasts, Scalp, Arms, And/Or Legs; 50 Cc Or Less Injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
15772	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk, Breasts, Scalp, Arms, And/Or Legs; Each Additional 50 Cc Injectate, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
15773	Grafting Of Autologous Fat Harvested By Liposuction Technique To Face, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, And/Or Feet; 25 Cc Or Less Injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
15774	Grafting Of Autologous Fat Harvested By Liposuction Technique To Face, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, And/Or Feet; Each Additional 25 Cc Injectate, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

15775	Punch Graft For Hair Transplant; 1 To 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15776	Punch Graft For Hair Transplant; More Than 15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15780	Dermabrasion; Total Face (Eg, For Acne Scarring, Fine Wrinkling, Rhytids, General Keratosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15781	Dermabrasion; Segmental, Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15782	Dermabrasion; Regional, Other Than Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15783	Dermabrasion; Superficial, Any Site (Eg, Tattoo Removal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15788	Chemical Peel, Facial; Epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15789	Chemical Peel, Facial; Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15792	Chemical Peel, Nonfacial; Epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15793	Chemical Peel, Nonfacial; Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15820	Blepharoplasty, Lower Eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15821	Blepharoplasty, Lower Eyelid; With Extensive Herniated Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15822	Blepharoplasty, Upper Eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15823	Blepharoplasty, Upper Eyelid; With Excessive Skin Weighting Down Lid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15824	Rhytidectomy; Forehead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999

15826	Rhytidectomy; Glabellar Frown Lines	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
15829	Rhytidectomy; Superficial Musculoaponeurotic System (Smas) Flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15830	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Abdomen, Infraumbilical Panniculectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15832	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15833	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15834	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15835	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Buttock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15836	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15837	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Forearm Or Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15838	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Submental Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15839	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Other Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15847	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy), Abdomen (Eg, Abdominoplasty) (Includes Umbilical Transposition And Fascial Plication) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15876	Suction Assisted Lipectomy; Head And Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15877	Suction Assisted Lipectomy; Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
15878	Suction Assisted Lipectomy; Upper Extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

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.	1/1/2013	12/31/2999
17106	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique); Less Than 10 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
17107	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique); 10.0 To 50.0 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
17108	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique); Over 50.0 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
17340	Cryotherapy (Co2 Slush, Liquid N2) For Acne	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
17360	Chemical Exfoliation For Acne (Eg, Acne Paste, Acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
17380	Electrolysis Epilation, Each 30 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19105	Ablation, Cryosurgical, Of Fibroadenoma, Including Ultrasound Guidance, Each Fibroadenoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19300	Mastectomy For Gynecomastia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
19303	Mastectomy, Simple, Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19316	Mastopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19325	Breast Augmentation With Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19328	Removal Of Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19330	Removal Of Ruptured Breast Implant, Including Implant Contents (Eg, Saline, Silicone Gel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19340	Insertion Of Breast Implant On Same Day Of Mastectomy (Ie, Immediate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

19342	Insertion Or Replacement Of Breast Implant On Separate Day From Mastectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19350	Nipple/Areola Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19355	Correction Of Inverted Nipples	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19357	Tissue Expander Placement In Breast Reconstruction, Including Subsequent Expansion(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19370	Revision Of Peri-Implant Capsule, Breast, Including Capsulotomy, Capsulorrhaphy, And/Or Partial Capsulectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19371	Peri-Implant Capsulectomy, Breast, Complete, Including Removal Of All Intracapsular Contents	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
19380	Revision Of Reconstructed Breast (Eg, Significant Removal Of Tissue, Re-Advancement And/Or Re-Inset Of Flaps In Autologous Reconstruction Or Significant Capsular Revision Combined With Soft Tissue Excision In Implant-Based Reconstruction)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
19396	Preparation Of Moulage For Custom Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
19499	Unlisted Procedure, Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
20527	Injection, Enzyme (Eg, Collagenase), Palmar Fascial Cord (Ie, Dupuytren'S Contracture)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
20560	Needle Insertion(S) Without Injection(S); 1 Or 2 Muscle(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
20561	Needle Insertion(S) Without Injection(S); 3 Or More Muscles	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
20932	Allograft, Includes Templating, Cutting, Placement And Internal Fixation, When Performed; Osteoarticular, Including Articular Surface And Contiguous Bone (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
20933	Allograft, Includes Templating, Cutting, Placement And Internal Fixation, When Performed; Hemicortical Intercalary, Partial (Ie, Hemicylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
20934	Allograft, Includes Templating, Cutting, Placement And Internal Fixation, When Performed; Intercalary, Complete (Ie, Cylindrical) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
20974	Electrical Stimulation To Aid Bone Healing; Noninvasive (Nonoperative)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

20975	Electrical Stimulation To Aid Bone Healing; Invasive (Operative)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
20979	Low Intensity Ultrasound Stimulation To Aid Bone Healing, Noninvasive (Nonoperative)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
20982	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg, Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension, Percutaneous, Including Imaging Guidance When Performed; Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg, Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension, Percutaneous, Including Imaging Guidance When Performed; Cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
20985	Computer-Assisted Surgical Navigational Procedure For Musculoskeletal Procedures, Image-Less (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
21010	Arthrotomy, Temporomandibular Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21025	Excision Of Bone (Eg, For Osteomyelitis Or Bone Abscess); Mandible	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21026	Excision Of Bone (Eg, For Osteomyelitis Or Bone Abscess); Facial Bone(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21050	Condylectomy, Temporomandibular Joint (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21060	Meniscectomy, Partial Or Complete, Temporomandibular Joint (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21070	Coronoidectomy (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21073	Manipulation Of Temporomandibular Joint(S) (Tmj), Therapeutic, Requiring An Anesthesia Service (Ie, General Or Monitored Anesthesia Care)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21085	Impression And Custom Preparation; Oral Surgical Splint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21110	Application Of Interdental Fixation Device For Conditions Other Than Fracture Or Dislocation, Includes Removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21120	Genioplasty; Augmentation (Autograft, Allograft, Prosthetic Material)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

21121	Genioplasty; Sliding Osteotomy, Single Piece	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21122	Genioplasty; Sliding Osteotomies, 2 Or More Osteotomies (Eg, Wedge Excision Or Bone Wedge Reversal For Asymmetrical Chin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21123	Genioplasty; Sliding, Augmentation With Interpositional Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
21141	Reconstruction Midface, Lefort I; Single Piece, Segment Movement In Any Direction (Eg, For Long Face Syndrome), Without Bone Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21142	Reconstruction Midface, Lefort I; 2 Pieces, Segment Movement In Any Direction, Without Bone Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21143	Reconstruction Midface, Lefort I; 3 Or More Pieces, Segment Movement In Any Direction, Without Bone Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999

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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
21193	Reconstruction Of Mandibular Rami, Horizontal, Vertical, C, Or L Osteotomy; Without Bone Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21194	Reconstruction Of Mandibular Rami, Horizontal, Vertical, C, Or L Osteotomy; With Bone Graft (Includes Obtaining Graft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21195	Reconstruction Of Mandibular Rami And/Or Body, Sagittal Split; Without Internal Rigid Fixation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21196	Reconstruction Of Mandibular Rami And/Or Body, Sagittal Split; With Internal Rigid Fixation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21198	Osteotomy, Mandible, Segmental;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21199	Osteotomy, Mandible, Segmental; With Genioglossus Advancement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
21209	Osteoplasty, Facial Bones; Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21210	Graft, Bone; Nasal, Maxillary Or Malar Areas (Includes Obtaining Graft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21240	Arthroplasty, Temporomandibular Joint, With Or Without Autograft (Includes Obtaining Graft)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2016	12/31/2999
21242	Arthroplasty, Temporomandibular Joint, With Allograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21243	Arthroplasty, Temporomandibular Joint, With Prosthetic Joint Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999

21244	Reconstruction Of Mandible, Extraoral, With Transosteal Bone Plate (Eg, Mandibular Staple Bone Plate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21245	Reconstruction Of Mandible Or Maxilla, Subperiosteal Implant; Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21246	Reconstruction Of Mandible Or Maxilla, Subperiosteal Implant; Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21282	Lateral Canthopexy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
21480	Closed Treatment Of Temporomandibular Dislocation; Initial Or Subsequent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21485	Closed Treatment Of Temporomandibular Dislocation; Complicated (Eg, Recurrent Requiring Intermaxillary Fixation Or Splinting), Initial Or Subsequent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21490	Open Treatment Of Temporomandibular Dislocation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
21685	Hyoid Myotomy And Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
21740	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2022	12/31/2999
21742	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive Approach (Nuss Procedure), Without Thoracoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2022	12/31/2999
21743	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive Approach (Nuss Procedure), With Thoracoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2022	12/31/2999
22505	Manipulation Of Spine Requiring Anesthesia, Any Region	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
22510	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed), 1 Vertebral Body, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance; Cervicothoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
22511	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed), 1 Vertebral Body, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance; Lumbosacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
22512	Percutaneous Vertebroplasty (Bone Biopsy Included When Performed), 1 Vertebral Body, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance; Each Additional Cervicothoracic Or Lumbosacral Vertebral Body (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999

22513	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg, Kyphoplasty), 1 Vertebral Body, Unilateral Or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
22514	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg, Kyphoplasty), 1 Vertebral Body, Unilateral Or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
22515	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (Eg, Kyphoplasty), 1 Vertebral Body, Unilateral Or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Each Additional Thoracic Or Lumbar Vertebral Body (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
22526	Percutaneous Intradiscal Electrothermal Annuloplasty, Unilateral Or Bilateral Including Fluoroscopic Guidance; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22527	Percutaneous Intradiscal Electrothermal Annuloplasty, Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or More Additional Levels (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22548	Arthrodesis, Anterior Transoral Or Extraoral Technique, Clivus-C1-C2 (Atlas-Axis), With Or Without Excision Of Odontoid Process	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22551	Arthrodesis, Anterior Interbody, Including Disc Space Preparation, Discectomy, Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22552	Arthrodesis, Anterior Interbody, Including Disc Space Preparation, Discectomy, Osteophytectomy And Decompression Of Spinal Cord And/Or Nerve Roots; Cervical Below C2, Each Additional Interspace (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22554	Arthrodesis, Anterior Interbody Technique, Including Minimal Discectomy To Prepare Interspace (Other Than For Decompression); Cervical Below C2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
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).	2/15/2015	12/31/2999
22590	Arthrodesis, Posterior Technique, Craniocervical (Occiput-C2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22595	Arthrodesis, Posterior Technique, Atlas-Axis (C1-C2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22600	Arthrodesis, Posterior Or Posterolateral Technique, Single Interspace; Cervical Below C2 Segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
22836	Anterior Thoracic Vertebral Body Tethering, Including Thoracoscopy, When Performed; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

22837	Anterior Thoracic Vertebral Body Tethering, Including Thoracoscopy, When Performed; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22838	Revision (Eg, Augmentation, Division Of Tether), Replacement, Or Removal Of Thoracic Vertebral Body Tethering, Including Thoracoscopy, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22867	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22869	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Open Decompression Or Fusion, Including Image Guidance When Performed, Lumbar; Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22870	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Open Decompression Or Fusion, Including Image Guidance When Performed, Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
23929	Unlisted Procedure, Shoulder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
24300	Manipulation, Elbow, Under Anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2015	12/31/2999
26341	Manipulation, Palmar Fascial Cord (Ie, Dupuytren'S Cord), Post Enzyme Injection (Eg, Collagenase), Single Cord	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27096	Injection Procedure For Sacroiliac Joint, Anesthetic/Steroid, With Image Guidance (Fluoroscopy Or Ct) Including Arthrography When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2020	12/31/2999
27275	Manipulation, Hip Joint, Requiring General Anesthesia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27278	Arthrodesis, Sacroiliac Joint, Percutaneous, With Image Guidance, Including Placement Of Intra-Articular Implant(S) (Eg, Bone Allograft[S], Synthetic Device[S]), Without Placement Of Transfixation Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
27279	Arthrodesis, Sacroiliac Joint, Percutaneous Or Minimally Invasive (Indirect Visualization), With Image Guidance, Includes Obtaining Bone Graft When Performed, And Placement Of Transfixing Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
27280	Arthrodesis, Sacroiliac Joint, Open, Includes Obtaining Bone Graft, Including Instrumentation, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2018	12/31/2999
27299	Unlisted Procedure, Pelvis Or Hip Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
27412	Autologous Chondrocyte Implantation, Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

27415	Osteochondral Allograft, Knee, Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27416	Osteochondral Autograft(S), Knee, Open (Eg, Mosaicplasty) (Includes Harvesting Of Autograft[S])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27702	Arthroplasty, Ankle; With Implant (Total Ankle)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27703	Arthroplasty, Ankle; Revision, Total Ankle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
27704	Removal Of Ankle Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
28446	Open Osteochondral Autograft, Talus (Includes Obtaining Graft[S])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2018	12/31/2999
28890	Extracorporeal Shock Wave, High Energy, Performed By A Physician Or Other Qualified Health Care Professional, Requiring Anesthesia Other Than Local, Including Ultrasound Guidance, Involving The Plantar Fascia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
29800	Arthroscopy, Temporomandibular Joint, Diagnostic, With Or Without Synovial Biopsy (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
29804	Arthroscopy, Temporomandibular Joint, Surgical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
29862	Arthroscopy, Hip, Surgical; With Debridement/Shaving Of Articular Cartilage (Chondroplasty), Abrasion Arthroplasty, And/Or Resection Of Labrum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
29866	Arthroscopy, Knee, Surgical; Osteochondral Autograft(S) (Eg, Mosaicplasty) (Includes Harvesting Of The Autograft[S])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
29867	Arthroscopy, Knee, Surgical; Osteochondral Allograft (Eg, Mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
29868	Arthroscopy, Knee, Surgical; Meniscal Transplantation (Includes Arthrotomy For Meniscal Insertion), Medial Or Lateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
29914	Arthroscopy, Hip, Surgical; With Femoroplasty (Ie, Treatment Of Cam Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
29915	Arthroscopy, Hip, Surgical; With Acetabuloplasty (Ie, Treatment Of Pincer Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
29916	Arthroscopy, Hip, Surgical; With Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

29999	Unlisted Procedure, Arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
30117	Excision Or Destruction (Eg, Laser), Intranasal Lesion; Internal Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2024	12/31/2999
30120	Excision Or Surgical Planing Of Skin Of Nose For Rhinophyma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30130	Excision Inferior Turbinate, Partial Or Complete, Any Method	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2024	12/31/2999
30140	Submucous Resection Inferior Turbinate, Partial Or Complete, Any Method	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2024	12/31/2999
30150	Rhinectomy; Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30400	Rhinoplasty, Primary; Lateral And Alar Cartilages And/Or Elevation Of Nasal Tip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30410	Rhinoplasty, Primary; Complete, External Parts Including Bony Pyramid, Lateral And Alar Cartilages, And/Or Elevation Of Nasal Tip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30420	Rhinoplasty, Primary; Including Major Septal Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30430	Rhinoplasty, Secondary; Minor Revision (Small Amount Of Nasal Tip Work)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30435	Rhinoplasty, Secondary; Intermediate Revision (Bony Work With Osteotomies)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30450	Rhinoplasty, Secondary; Major Revision (Nasal Tip Work And Osteotomies)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
30468	Repair Of Nasal Valve Collapse With Subcutaneous/Submucosal Lateral Wall Implant(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
30469	Repair Of Nasal Valve Collapse With Low Energy, Temperature-Controlled (Ie, Radiofrequency) Subcutaneous/Submucosal Remodeling	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
30520	Septoplasty Or Submucous Resection, With Or Without Cartilage Scoring, Contouring Or Replacement With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2024	12/31/2999
30801	Ablation, Soft Tissue Of Inferior Turbinates, Unilateral Or Bilateral, Any Method (Eg, Electrocautery, Radiofrequency Ablation, Or Tissue Volume Reduction); Superficial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

30802	Ablation, Soft Tissue Of Inferior Turbinates, Unilateral Or Bilateral, Any Method (Eg, Electrocautery, Radiofrequency Ablation, Or Tissue Volume Reduction); Intramural (Ie, Submucosal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
31242	Nasal/Sinus Endoscopy, Surgical; With Destruction By Radiofrequency Ablation, Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
31243	Nasal/Sinus Endoscopy, Surgical; With Destruction By Cryoablation, Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
31295	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Maxillary Sinus Ostium, Transnasal Or Via Canine Fossa	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2018	12/31/2999
31296	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Frontal Sinus Ostium	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2018	12/31/2999
31297	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Sphenoid Sinus Ostium	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2018	12/31/2999
31298	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Frontal And Sphenoid Sinus Ostia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
31634	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When Performed; With Balloon Occlusion, With Assessment Of Air Leak, With Administration Of Occlusive Substance (Eg, Fibrin Glue), If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2020	12/31/2999
31648	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When Performed; With Removal Of Bronchial Valve(S), Initial Lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
31649	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When Performed; With Removal Of Bronchial Valve(S), Each Additional Lobe (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
31660	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When Performed; With Bronchial Thermoplasty, 1 Lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
31661	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When Performed; With Bronchial Thermoplasty, 2 Or More Lobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32553	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Percutaneous, Intra-Thoracic, Single Or Multiple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
32850	Donor Pneumonectomy(S) (Including Cold Preservation), From Cadaver Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32851	Lung Transplant, Single; Without Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32852	Lung Transplant, Single; With Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

32853	Lung Transplant, Double (Bilateral Sequential Or En Bloc); Without Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32854	Lung Transplant, Double (Bilateral Sequential Or En Bloc); With Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32855	Backbench Standard Preparation Of Cadaver Donor Lung Allograft Prior To Transplantation, Including Dissection Of Allograft From Surrounding Soft Tissues To Prepare Pulmonary Venous/Atrial Cuff, Pulmonary Artery, And Bronchus; Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32856	Backbench Standard Preparation Of Cadaver Donor Lung Allograft Prior To Transplantation, Including Dissection Of Allograft From Surrounding Soft Tissues To Prepare Pulmonary Venous/Atrial Cuff, Pulmonary Artery, And Bronchus; Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
32994	Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension, Percutaneous, Including Imaging Guidance When Performed, Unilateral; Cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2018	12/31/2999
32998	Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension, Percutaneous, Including Imaging Guidance When Performed, Unilateral; Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33202	Insertion Of Epicardial Electrode(S); Open Incision (Eg, Thoracotomy, Median Sternotomy, Subxiphoid Approach)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33203	Insertion Of Epicardial Electrode(S); Endoscopic Approach (Eg, Thoracoscopy, Pericardioscopy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	11/1/2016	12/31/2999
33213	Insertion Of Pacemaker Pulse Generator Only; With Existing Dual Leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33216	Insertion Of A Single Transvenous Electrode, Permanent Pacemaker Or Implantable Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33217	Insertion Of 2 Transvenous Electrodes, Permanent Pacemaker Or Implantable Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33218	Repair Of Single Transvenous Electrode, Permanent Pacemaker Or Implantable Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33220	Repair Of 2 Transvenous Electrodes For Permanent Pacemaker Or Implantable Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33223	Relocation Of Skin Pocket For Implantable Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999

33224	Insertion Of Pacing Electrode, Cardiac Venous System, For Left Ventricular Pacing, With Attachment To Previously Placed Pacemaker Or Implantable Defibrillator Pulse Generator (Including Revision Of Pocket, Removal, Insertion, And/Or Replacement Of Existing Generator)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33225	Insertion Of Pacing Electrode, Cardiac Venous System, For Left Ventricular Pacing, At Time Of Insertion Of Implantable Defibrillator Or Pacemaker Pulse Generator (Eg, For Upgrade To Dual Chamber System) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33230	Insertion Of Implantable Defibrillator Pulse Generator Only; With Existing Dual Leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33231	Insertion Of Implantable Defibrillator Pulse Generator Only; With Existing Multiple Leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33240	Insertion Of Implantable Defibrillator Pulse Generator Only; With Existing Single Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33241	Removal Of Implantable Defibrillator Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33243	Removal Of Single Or Dual Chamber Implantable Defibrillator Electrode(S); By Thoracotomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33244	Removal Of Single Or Dual Chamber Implantable Defibrillator Electrode(S); By Transvenous Extraction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33249	Insertion Or Replacement Of Permanent Implantable Defibrillator System, With Transvenous Lead(S), Single Or Dual Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33262	Removal Of Implantable Defibrillator Pulse Generator With Replacement Of Implantable Defibrillator Pulse Generator; Single Lead System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33263	Removal Of Implantable Defibrillator Pulse Generator With Replacement Of Implantable Defibrillator Pulse Generator; Dual Lead System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33264	Removal Of Implantable Defibrillator Pulse Generator With Replacement Of Implantable Defibrillator Pulse Generator; Multiple Lead System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
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.	1/1/2022	12/31/2999
33268	Exclusion Of Left Atrial Appendage, Open, Performed At The Time Of Other Sternotomy Or Thoracotomy Procedure(S), Any Method (Eg, Excision, Isolation Via Stapling, Oversewing, Ligation, Plication, Clip) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
33269	Exclusion Of Left Atrial Appendage, Thoracoscopic, Any Method (Eg, Excision, Isolation Via Stapling, Oversewing, Ligation, Plication, Clip)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999

33270	Insertion Or Replacement Of Permanent Subcutaneous Implantable Defibrillator System, With Subcutaneous Electrode, Including Defibrillation Threshold Evaluation, Induction Of Arrhythmia, Evaluation Of Sensing For Arrhythmia Termination, And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
33271	Insertion Of Subcutaneous Implantable Defibrillator Electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
33272	Removal Of Subcutaneous Implantable Defibrillator Electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
33273	Repositioning Of Previously Implanted Subcutaneous Implantable Defibrillator Electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
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.	5/1/2020	12/31/2999
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.	5/1/2020	12/31/2999
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]), Including Vessel Catheterization, All Imaging Guidance, And Pulse Generator Initial Analysis With Diagnostic Mode Activation, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33278	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; System, Including Pulse Generator And Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33279	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33280	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Pulse Generator Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33285	Insertion, Subcutaneous Cardiac Rhythm Monitor, Including Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
33286	Removal, Subcutaneous Cardiac Rhythm Monitor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999

33287	Removal And Replacement Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Pulse Generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33288	Removal And Replacement Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Transvenous Stimulation Or Sensing Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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.	9/1/2020	12/31/2999
33340	Percutaneous Transcatheter Closure Of The Left Atrial Appendage With Endocardial Implant, Including Fluoroscopy, Transseptal Puncture, Catheter Placement(S), Left Atrial Angiography, Left Atrial Appendage Angiography, When Performed, And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
33361	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Percutaneous Femoral Artery Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33362	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Femoral Artery Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33363	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Axillary Artery Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33364	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Iliac Artery Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33365	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Transaortic Approach (Eg, Median Sternotomy, Mediastinotomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33366	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Transapical Exposure (Eg, Left Thoracotomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
33367	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Percutaneous Peripheral Arterial And Venous Cannulation (Eg, Femoral Vessels) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33368	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Open Peripheral Arterial And Venous Cannulation (Eg, Femoral, Iliac, Axillary Vessels) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33369	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Central Arterial And Venous Cannulation (Eg, Aorta, Right Atrium, Pulmonary Artery) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

33370	Transcatheter Placement And Subsequent Removal Of Cerebral Embolic Protection Device(S), Including Arterial Access, Catheterization, Imaging, And Radiological Supervision And Interpretation, Percutaneous (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
33418	Transcatheter Mitral Valve Repair, Percutaneous Approach, Including Transseptal Puncture When Performed; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
33419	Transcatheter Mitral Valve Repair, Percutaneous Approach, Including Transseptal Puncture When Performed; Additional Prosthesis(Es) During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
33477	Transcatheter Pulmonary Valve Implantation, Percutaneous Approach, Including Pre-Stenting Of The Valve Delivery Site, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
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.	1/1/2013	12/31/2999
33548	Surgical Ventricular Restoration Procedure, Includes Prosthetic Patch, When Performed (Eg, Ventricular Remodeling, Svr, Saver, Dor Procedures)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
33897	Percutaneous Transluminal Angioplasty Of Native Or Recurrent Coarctation Of The Aorta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
33927	Implantation Of A Total Replacement Heart System (Artificial Heart) With Recipient Cardiectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
33928	Removal And Replacement Of Total Replacement Heart System (Artificial Heart)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
33929	Removal Of A Total Replacement Heart System (Artificial Heart) For Heart Transplantation (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
33930	Donor Cardiectomy-Pneumonectomy (Including Cold Preservation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999
33933	Backbench Standard Preparation Of Cadaver Donor Heart/Lung Allograft Prior To Transplantation, Including Dissection Of Allograft From Surrounding Soft Tissues To Prepare Aorta, Superior Vena Cava, Inferior Vena Cava, And Trachea For Implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999
33935	Heart-Lung Transplant With Recipient Cardiectomy-Pneumonectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999
33940	Donor Cardiectomy (Including Cold Preservation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999
33944	Backbench Standard Preparation Of Cadaver Donor Heart Allograft Prior To Transplantation, Including Dissection Of Allograft From Surrounding Soft Tissues To Prepare Aorta, Superior Vena Cava, Inferior Vena Cava, Pulmonary Artery, And Left Atrium For Implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999

33945	Heart Transplant, With Or Without Recipient Cardiectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2017	12/31/2999
33975	Insertion Of Ventricular Assist Device; Extracorporeal, Single Ventricle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33976	Insertion Of Ventricular Assist Device; Extracorporeal, Biventricular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33977	Removal Of Ventricular Assist Device; Extracorporeal, Single Ventricle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33978	Removal Of Ventricular Assist Device; Extracorporeal, Biventricular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33979	Insertion Of Ventricular Assist Device, Implantable Intracorporeal, Single Ventricle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33980	Removal Of Ventricular Assist Device, Implantable Intracorporeal, Single Ventricle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33981	Replacement Of Extracorporeal Ventricular Assist Device, Single Or Biventricular, Pump(S), Single Or Each Pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33982	Replacement Of Ventricular Assist Device Pump(S); Implantable Intracorporeal, Single Ventricle, Without Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33983	Replacement Of Ventricular Assist Device Pump(S); Implantable Intracorporeal, Single Ventricle, With Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33990	Insertion Of Ventricular Assist Device, Percutaneous, Including Radiological Supervision And Interpretation; Left Heart, Arterial Access Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33991	Insertion Of Ventricular Assist Device, Percutaneous, Including Radiological Supervision And Interpretation; Left Heart, Both Arterial And Venous Access, With Transseptal Puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33992	Removal Of Percutaneous Left Heart Ventricular Assist Device, Arterial Or Arterial And Venous Cannula(S), At Separate And Distinct Session From Insertion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33993	Repositioning Of Percutaneous Right Or Left Heart Ventricular Assist Device With Imaging Guidance At Separate And Distinct Session From Insertion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33995	Insertion Of Ventricular Assist Device, Percutaneous, Including Radiological Supervision And Interpretation; Right Heart, Venous Access Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
33997	Removal Of Percutaneous Right Heart Ventricular Assist Device, Venous Cannula, At Separate And Distinct Session From Insertion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999

33999	Unlisted Procedure, Cardiac Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
36465	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate, Inclusive Of All Imaging Guidance And Monitoring; Single Incompetent Extremity Truncal Vein (Eg, Great Saphenous Vein, Accessory Saphenous Vein)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
36466	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate, Inclusive Of All Imaging Guidance And Monitoring; Multiple Incompetent Truncal Veins (Eg, Great Saphenous Vein, Accessory Saphenous Vein), Same Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
36468	Injection(S) Of Sclerosant For Spider Veins (Telangiectasia), Limb Or Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36470	Injection Of Sclerosant; Single Incompetent Vein (Other Than Telangiectasia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36471	Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia), Same Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36473	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Mechanochemical; First Vein Treated	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
36474	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Mechanochemical; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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.	1/1/2013	12/31/2999
36476	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Radiofrequency; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36478	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Laser; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36479	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Laser; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36482	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, By Transcatheter Delivery Of A Chemical Adhesive (Eg, Cyanoacrylate) Remote From The Access Site, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999

36483	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, By Transcatheter Delivery Of A Chemical Adhesive (Eg, Cyanoacrylate) Remote From The Access Site, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36511	Therapeutic Apheresis; For White Blood Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2020	12/31/2999
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.	1/1/2013	12/31/2999
36522	Photopheresis, Extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
36836	Percutaneous Arteriovenous Fistula Creation, Upper Extremity, Single Access Of Both The Peripheral Artery And Peripheral Vein, Including Fistula Maturation Procedures (Eg, Transluminal Balloon Angioplasty, Coil Embolization) When Performed, Including All Vascular Access, Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
36837	Percutaneous Arteriovenous Fistula Creation, Upper Extremity, Separate Access Sites Of The Peripheral Artery And Peripheral Vein, Including Fistula Maturation Procedures (Eg, Transluminal Balloon Angioplasty, Coil Embolization) When Performed, Including All Vascular Access, Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
37215	Transcatheter Placement Of Intravascular Stent(S), Cervical Carotid Artery, Open Or Percutaneous, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation; With Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37216	Transcatheter Placement Of Intravascular Stent(S), Cervical Carotid Artery, Open Or Percutaneous, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation; Without Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37217	Transcatheter Placement Of Intravascular Stent(S), Intrathoracic Common Carotid Artery Or Innominate Artery By Retrograde Treatment, Open Ipsilateral Cervical Carotid Artery Exposure, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2014	12/31/2999
37218	Transcatheter Placement Of Intravascular Stent(S), Intrathoracic Common Carotid Artery Or Innominate Artery, Open Or Percutaneous Antegrade Approach, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
37241	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary To Complete The Intervention; Venous, Other Than Hemorrhage (Eg, Congenital Or Acquired Venous Malformations, Venous And Capillary Hemangiomas, Varices, Varicoceles)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

37242	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary To Complete The Intervention; Arterial, Other Than Hemorrhage Or Tumor (Eg, Congenital Or Acquired Arterial Malformations, Arteriovenous Malformations, Arteriovenous Fistulas, Aneurysms, Pseudoaneurysms)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37243	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary To Complete The Intervention; For Tumors, Organ Ischemia, Or Infarction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37244	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary To Complete The Intervention; For Arterial Or Venous Hemorrhage Or Lymphatic Extravasation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
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.	1/1/2013	12/31/2999
37700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction, Or Distal Interruptions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37718	Ligation, Division, And Stripping, Short Saphenous Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins From Saphenofemoral Junction To Knee Or Below	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins With Radical Excision Of Ulcer And Skin Graft And/Or Interruption Of Communicating Veins Of Lower Leg, With Excision Of Deep Fascia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37760	Ligation Of Perforator Veins, Subfascial, Radical (Linton Type), Including Skin Graft, When Performed, Open,1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37761	Ligation Of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37766	Stab Phlebectomy Of Varicose Veins, 1 Extremity; More Than 20 Incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37780	Ligation And Division Of Short Saphenous Vein At Saphenopopliteal Junction (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37785	Ligation, Division, And/Or Excision Of Varicose Vein Cluster(S), 1 Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

37788	Penile Revascularization, Artery, With Or Without Vein Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
37790	Penile Venous Occlusive Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38204	Management Of Recipient Hematopoietic Progenitor Cell Donor Search And Cell Acquisition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38205	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation, Per Collection; Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38207	Transplant Preparation Of Hematopoietic Progenitor Cells; Cryopreservation And Storage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38208	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest, Without Washing, Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38209	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest, With Washing, Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38210	Transplant Preparation Of Hematopoietic Progenitor Cells; Specific Cell Depletion Within Harvest, T-Cell Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38211	Transplant Preparation Of Hematopoietic Progenitor Cells; Tumor Cell Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38212	Transplant Preparation Of Hematopoietic Progenitor Cells; Red Blood Cell Removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38213	Transplant Preparation Of Hematopoietic Progenitor Cells; Platelet Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38214	Transplant Preparation Of Hematopoietic Progenitor Cells; Plasma (Volume) Depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38215	Transplant Preparation Of Hematopoietic Progenitor Cells; Cell Concentration In Plasma, Mononuclear, Or Buffy Coat Layer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38232	Bone Marrow Harvesting For Transplantation; Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38240	Hematopoietic Progenitor Cell (Hpc); Allogeneic Transplantation Per Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
38242	Allogeneic Lymphocyte Infusions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

38243	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2014	12/31/2999
38308	Lymphangiotomy Or Other Operations On Lymphatic Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2016	12/31/2999
41120	Glossectomy; Less Than One-Half Tongue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
41512	Tongue Base Suspension, Permanent Suture Technique	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
41530	Submucosal Ablation Of The Tongue Base, Radiofrequency, 1 Or More Sites, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
41872	Gingivoplasty, Each Quadrant (Specify)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
42140	Uvulectomy, Excision Of Uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
42145	Palatopharyngoplasty (Eg, Uvulopalatopharyngoplasty, Uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
42950	Pharyngoplasty (Plastic Or Reconstructive Operation On Pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
43192	Esophagoscopy, Rigid, 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.	11/1/2014	12/31/2999
43201	Esophagoscopy, Flexible, Transoral; With Directed Submucosal Injection(S), Any Substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43206	Esophagoscopy, Flexible, Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
43210	Esophagogastroduodenoscopy, Flexible, Transoral; With Esophagogastric Fundoplasty, Partial Or Complete, Includes Duodenoscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2016	12/31/2999
43229	Esophagoscopy, Flexible, Transoral; With Ablation Of Tumor(S), Polyp(S), Or Other Lesion(S) (Includes Pre- And Post-Dilation And Guide Wire Passage, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
43236	Esophagogastroduodenoscopy, Flexible, Transoral; With Directed Submucosal Injection(S), Any Substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43252	Esophagogastroduodenoscopy, Flexible, Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999

43253	Esophagogastroduodenoscopy, Flexible, Transoral; With Transendoscopic Ultrasound-Guided Transmural Injection Of Diagnostic Or Therapeutic Substance(S) (Eg, Anesthetic, Neurolytic Agent) Or Fiducial Marker(S) (Includes Endoscopic Ultrasound Examination Of The Esophagus, Stomach, And Either The Duodenum Or A Surgically Altered Stomach Where The Jejunum Is Examined Distal To The Anastomosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
43257	Esophagogastroduodenoscopy, Flexible, Transoral; With Delivery Of Thermal Energy To The Muscle Of Lower Esophageal Sphincter And/Or Gastric Cardia, For Treatment Of Gastroesophageal Reflux Disease	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43270	Esophagogastroduodenoscopy, Flexible, Transoral; With Ablation Of Tumor(S), Polyp(S), Or Other Lesion(S) (Includes Pre- And Post-Dilation And Guide Wire Passage, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
43284	Laparoscopy, Surgical, Esophageal Sphincter Augmentation Procedure, Placement Of Sphincter Augmentation Device (Ie, Magnetic Band), Including Cruroplasty When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
43285	Removal Of Esophageal Sphincter Augmentation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
43289	Unlisted Laparoscopy Procedure, Esophagus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
43290	Esophagogastroduodenoscopy, Flexible, Transoral; With Deployment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
43291	Esophagogastroduodenoscopy, Flexible, Transoral; With Removal Of Intragastric Bariatric Balloon(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
43497	Lower Esophageal Myotomy, Transoral (Ie, Peroral Endoscopic Myotomy [Poem])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
43632	Gastrectomy, Partial, Distal; With Gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
43633	Gastrectomy, Partial, Distal; With Roux-En-Y Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43644	Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb 150 Cm Or Less)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43645	Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43647	Laparoscopy, Surgical; Implantation Or Replacement Of Gastric Neurostimulator Electrodes, Antrum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43648	Laparoscopy, Surgical; Revision Or Removal Of Gastric Neurostimulator Electrodes, Antrum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

43770	Laparoscopy, Surgical, Gastric Restrictive Procedure; Placement Of Adjustable Gastric Restrictive Device (Eg, Gastric Band And Subcutaneous Port Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43771	Laparoscopy, Surgical, Gastric Restrictive Procedure; Revision Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43772	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43773	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal And Replacement Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43774	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device And Subcutaneous Port Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43775	Laparoscopy, Surgical, Gastric Restrictive Procedure; Longitudinal Gastrectomy (Ie, Sleeve Gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43842	Gastric Restrictive Procedure, Without Gastric Bypass, For Morbid Obesity; Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43843	Gastric Restrictive Procedure, Without Gastric Bypass, For Morbid Obesity; Other Than Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43845	Gastric Restrictive Procedure With Partial Gastrectomy, Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50 To 100 Cm Common Channel) To Limit Absorption (Biliopancreatic Diversion With Duodenal Switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43846	Gastric Restrictive Procedure, With Gastric Bypass For Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-Y Gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43847	Gastric Restrictive Procedure, With Gastric Bypass For Morbid Obesity; With Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
43848	Revision, Open, Of Gastric Restrictive Procedure For Morbid Obesity, Other Than Adjustable Gastric Restrictive Device (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43881	Implantation Or Replacement Of Gastric Neurostimulator Electrodes, Antrum, Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43882	Revision Or Removal Of Gastric Neurostimulator Electrodes, Antrum, Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43886	Gastric Restrictive Procedure, Open; Revision Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
43887	Gastric Restrictive Procedure, Open; Removal Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

43888	Gastric Restrictive Procedure, Open; Removal And Replacement Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
44132	Donor Enterectomy (Including Cold Preservation), Open; From Cadaver Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44133	Donor Enterectomy (Including Cold Preservation), Open; Partial, From Living Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44135	Intestinal Allotransplantation; From Cadaver Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44136	Intestinal Allotransplantation; From Living Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44137	Removal Of Transplanted Intestinal Allograft, Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44705	Preparation Of Fecal Microbiota For Instillation, Including Assessment Of Donor Specimen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2016	12/31/2999
44715	Backbench Standard Preparation Of Cadaver Or Living Donor Intestine Allograft Prior To Transplantation, Including Mobilization And Fashioning Of The Superior Mesenteric Artery And Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44720	Backbench Reconstruction Of Cadaver Or Living Donor Intestine Allograft Prior To Transplantation; Venous Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
44721	Backbench Reconstruction Of Cadaver Or Living Donor Intestine Allograft Prior To Transplantation; Arterial Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
46707	Repair Of Anorectal Fistula With Plug (Eg, Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
47133	Donor Hepatectomy (Including Cold Preservation), From Cadaver Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47135	Liver Allotransplantation, Orthotopic, Partial Or Whole, From Cadaver Or Living Donor, Any Age	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47140	Donor Hepatectomy (Including Cold Preservation), From Living Donor; Left Lateral Segment Only (Segments Ii And Iii)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47141	Donor Hepatectomy (Including Cold Preservation), From Living Donor; Total Left Lobectomy (Segments Ii, Iii And Iv)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47142	Donor Hepatectomy (Including Cold Preservation), From Living Donor; Total Right Lobectomy (Segments V, Vi, Vii And Viii)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999

47143	Backbench Standard Preparation Of Cadaver Donor Whole Liver Graft Prior To Allotransplantation, Including Cholecystectomy, If Necessary, And Dissection And Removal Of Surrounding Soft Tissues To Prepare The Vena Cava, Portal Vein, Hepatic Artery, And Common Bile Duct For Implantation; Without Trisegment Or Lobe Split	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47144	Backbench Standard Preparation Of Cadaver Donor Whole Liver Graft Prior To Allotransplantation, Including Cholecystectomy, If Necessary, And Dissection And Removal Of Surrounding Soft Tissues To Prepare The Vena Cava, Portal Vein, Hepatic Artery, And Common Bile Duct For Implantation; With Trisegment Split Of Whole Liver Graft Into 2 Partial Liver Grafts (Ie, Left Lateral Segment [Segments Ii And Iii] And Right Trisegment [Segments I And Iv Through Viii])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47145	Backbench Standard Preparation Of Cadaver Donor Whole Liver Graft Prior To Allotransplantation, Including Cholecystectomy, If Necessary, And Dissection And Removal Of Surrounding Soft Tissues To Prepare The Vena Cava, Portal Vein, Hepatic Artery, And Common Bile Duct For Implantation; With Lobe Split Of Whole Liver Graft Into 2 Partial Liver Grafts (Ie, Left Lobe [Segments Ii, Iii, And Iv] And Right Lobe [Segments I And V Through Viii])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47146	Backbench Reconstruction Of Cadaver Or Living Donor Liver Graft Prior To Allotransplantation; Venous Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47147	Backbench Reconstruction Of Cadaver Or Living Donor Liver Graft Prior To Allotransplantation; Arterial Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
47370	Laparoscopy, Surgical, Ablation Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
47371	Laparoscopy, Surgical, Ablation Of 1 Or More Liver Tumor(S); Cryosurgical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
47380	Ablation, Open, Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
47381	Ablation, Open, Of 1 Or More Liver Tumor(S); Cryosurgical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
47382	Ablation, 1 Or More Liver Tumor(S), Percutaneous, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
47383	Ablation, 1 Or More Liver Tumor(S), Percutaneous, Cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
48160	Pancreatectomy, Total Or Subtotal, With Autologous Transplantation Of Pancreas Or Pancreatic Islet Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
48550	Donor Pancreatectomy (Including Cold Preservation), With Or Without Duodenal Segment For Transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

48551	Backbench Standard Preparation Of Cadaver Donor Pancreas Allograft Prior To Transplantation, Including Dissection Of Allograft From Surrounding Soft Tissues, Splenectomy, Duodenotomy, Ligation Of Bile Duct, Ligation Of Mesenteric Vessels, And Y-Graft Arterial Anastomoses From Iliac Artery To Superior Mesenteric Artery And To Splenic Artery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
48552	Backbench Reconstruction Of Cadaver Donor Pancreas Allograft Prior To Transplantation, Venous Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
48554	Transplantation Of Pancreatic Allograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
48556	Removal Of Transplanted Pancreatic Allograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
49411	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Percutaneous, Intra-Abdominal, Intra-Pelvic (Except Prostate), And/Or Retroperitoneum, Single Or Multiple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
49412	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Open, Intra-Abdominal, Intrapelvic, And/Or Retroperitoneum, Including Image Guidance, If Performed, Single Or Multiple (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
50250	Ablation, Open, 1 Or More Renal Mass Lesion(S), Cryosurgical, Including Intraoperative Ultrasound Guidance And Monitoring, If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
50300	Donor Nephrectomy (Including Cold Preservation); From Cadaver Donor, Unilateral Or Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50320	Donor Nephrectomy (Including Cold Preservation); Open, From Living Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50323	Backbench Standard Preparation Of Cadaver Donor Renal Allograft Prior To Transplantation, Including Dissection And Removal Of Perinephric Fat, Diaphragmatic And Retroperitoneal Attachments, Excision Of Adrenal Gland, And Preparation Of Ureter(S), Renal Vein(S), And Renal Artery(S), Ligating Branches, As Necessary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50325	Backbench Standard Preparation Of Living Donor Renal Allograft (Open Or Laparoscopic) Prior To Transplantation, Including Dissection And Removal Of Perinephric Fat And Preparation Of Ureter(S), Renal Vein(S), And Renal Artery(S), Ligating Branches, As Necessary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50327	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Venous Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50328	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Arterial Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999

50329	Backbench Reconstruction Of Cadaver Or Living Donor Renal Allograft Prior To Transplantation; Ureteral Anastomosis, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50340	Recipient Nephrectomy (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50360	Renal Allotransplantation, Implantation Of Graft; Without Recipient Nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2016	12/31/2999
50365	Renal Allotransplantation, Implantation Of Graft; With Recipient Nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50370	Removal Of Transplanted Renal Allograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50541	Laparoscopy, Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
50542	Laparoscopy, Surgical; Ablation Of Renal Mass Lesion(S), Including Intraoperative Ultrasound Guidance And Monitoring, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
50547	Laparoscopy, Surgical; Donor Nephrectomy (Including Cold Preservation), From Living Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
50592	Ablation, 1 Or More Renal Tumor(S), Percutaneous, Unilateral, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
50593	Ablation, Renal Tumor(S), Unilateral, Percutaneous, Cryotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
51715	Endoscopic Injection Of Implant Material Into The Submucosal Tissues Of The Urethra And/Or Bladder Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
52284	Cystourethroscopy, With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis, Male, Including Fluoroscopy, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
52287	Cystourethroscopy, With Injection(S) For Chemodenervation Of The Bladder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
52327	Cystourethroscopy (Including Ureteral Catheterization); With Subureteric Injection Of Implant Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
52441	Cystourethroscopy, With Insertion Of Permanent Adjustable Transprostatic Implant; Single Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
52442	Cystourethroscopy, With Insertion Of Permanent Adjustable Transprostatic Implant; Each Additional Permanent Adjustable Transprostatic Implant (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999

53451	Periurethral Transperineal Adjustable Balloon Continence Device; Bilateral Insertion, Including Cystourethroscopy And Imaging Guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53452	Periurethral Transperineal Adjustable Balloon Continence Device; Unilateral Insertion, Including Cystourethroscopy And Imaging Guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53453	Periurethral Transperineal Adjustable Balloon Continence Device; Removal, Each Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53454	Periurethral Transperineal Adjustable Balloon Continence Device; Percutaneous Adjustment Of Balloon(S) Fluid Volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53855	Insertion Of A Temporary Prostatic Urethral Stent, Including Urethral Measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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).	2/15/2015	12/31/2999
54125	Amputation Of Penis; Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54200	Injection Procedure For Peyronie Disease;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54205	Injection Procedure For Peyronie Disease; With Surgical Exposure Of Plaque	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
54240	Penile Plethysmography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
54360	Plastic Operation On Penis To Correct Angulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54400	Insertion Of Penile Prosthesis; Non-Inflatable (Semi-Rigid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54401	Insertion Of Penile Prosthesis; Inflatable (Self-Contained)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54405	Insertion Of Multi-Component, Inflatable Penile Prosthesis, Including Placement Of Pump, Cylinders, And Reservoir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54406	Removal Of All Components Of A Multi-Component, Inflatable Penile Prosthesis Without Replacement Of Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

54408	Repair Of Component(S) Of A Multi-Component, Inflatable Penile Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54410	Removal And Replacement Of All Component(S) Of A Multi-Component, Inflatable Penile Prosthesis At The Same Operative Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54411	Removal And Replacement Of All Components Of A Multi-Component Inflatable Penile Prosthesis Through An Infected Field At The Same Operative Session, Including Irrigation And Debridement Of Infected Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54415	Removal Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis, Without Replacement Of Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54416	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis At The Same Operative Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54417	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis Through An Infected Field At The Same Operative Session, Including Irrigation And Debridement Of Infected Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54660	Insertion Of Testicular Prosthesis (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
54900	Epididymovasostomy, Anastomosis Of Epididymis To Vas Deferens; Unilateral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
54901	Epididymovasostomy, Anastomosis Of Epididymis To Vas Deferens; Bilateral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
55400	Vasovasostomy, Vasovasorrhaphy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
55706	Biopsies, Prostate, Needle, Transperineal, Stereotactic Template Guided Saturation Sampling, Including Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
55870	Electroejaculation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
55873	Cryosurgical Ablation Of The Prostate (Includes Ultrasonic Guidance And Monitoring)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
55876	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Prostate (Via Needle, Any Approach), Single Or Multiple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
55880	Ablation Of Malignant Prostate Tissue, Transrectal, With High Intensity-Focused Ultrasound (Hifu), Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
55970	Intersex Surgery; Male To Female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
55980	Intersex Surgery; Female To Male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

56700	Partial Hymenectomy Or Revision Of Hymenal Ring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
56805	Clitoroplasty For Intersex State	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
57291	Construction Of Artificial Vagina; Without Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
57292	Construction Of Artificial Vagina; With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
57295	Revision (Including Removal) Of Prosthetic Vaginal Graft; Vaginal Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
57296	Revision (Including Removal) Of Prosthetic Vaginal Graft; Open Abdominal Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
57335	Vaginoplasty For Intersex State	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
57426	Revision (Including Removal) Of Prosthetic Vaginal Graft, Laparoscopic Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
58580	Transcervical Ablation Of Uterine Fibroid(S), Including Intraoperative Ultrasound Guidance And Monitoring, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
58674	Laparoscopy, Surgical, 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.	1/1/2017	12/31/2999
58750	Tubotubal Anastomosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
58752	Tubouterine Implantation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
58970	Follicle Puncture For Oocyte Retrieval, Any Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
58974	Embryo Transfer, Intrauterine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
58976	Gamete, Zygote, Or Embryo Intrafallopian Transfer, Any Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
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.	3/1/2021	12/31/2999
59074	Fetal Fluid Drainage (Eg, Vesicocentesis, Thoracocentesis, Paracentesis), Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

59076	Fetal Shunt Placement, Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
59897	Unlisted Fetal Invasive Procedure, Including Ultrasound Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
60699	Unlisted Procedure, Endocrine System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
61630	Balloon Angioplasty, Intracranial (Eg, Atherosclerotic Stenosis), Percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
61645	Percutaneous Arterial Transluminal Mechanical Thrombectomy And/Or Infusion For Thrombolysis, Intracranial, Any Method, Including Diagnostic Angiography, Fluoroscopic Guidance, Catheter Placement, And Intraprocedural Pharmacological Thrombolytic Injection(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
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.	1/1/2016	12/31/2999
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.	1/1/2016	12/31/2999
61736	Laser Interstitial Thermal Therapy (Litt) Of Lesion, Intracranial, Including Burr Hole(S), With Magnetic Resonance Imaging Guidance, When Performed; Single Trajectory For 1 Simple Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
61737	Laser Interstitial Thermal Therapy (Litt) Of Lesion, Intracranial, Including Burr Hole(S), With Magnetic Resonance Imaging Guidance, When Performed; Multiple Trajectories For Multiple Or Complex Lesion(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
61850	Twist Drill Or Burr Hole(S) For Implantation Of Neurostimulator Electrodes, Cortical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61860	Craniectomy Or Craniotomy For Implantation Of Neurostimulator Electrodes, Cerebral, Cortical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61863	Twist Drill, Burr Hole, Craniotomy, Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg, Thalamus, Globus Pallidus, Subthalamic Nucleus, Periventricular, Periaqueductal Gray), Without Use Of Intraoperative Microelectrode Recording; First Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

61864	Twist Drill, Burr Hole, Craniotomy, Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg, Thalamus, Globus Pallidus, Subthalamic Nucleus, Periventricular, Periaqueductal Gray), Without Use Of Intraoperative Microelectrode Recording; Each Additional Array (List Separately In Addition To Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61867	Twist Drill, Burr Hole, Craniotomy, Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg, Thalamus, Globus Pallidus, Subthalamic Nucleus, Periventricular, Periaqueductal Gray), With Use Of Intraoperative Microelectrode Recording; First Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61868	Twist Drill, Burr Hole, Craniotomy, Or Craniectomy With Stereotactic Implantation Of Neurostimulator Electrode Array In Subcortical Site (Eg, Thalamus, Globus Pallidus, Subthalamic Nucleus, Periventricular, Periaqueductal Gray), With Use Of Intraoperative Microelectrode Recording; Each Additional Array (List Separately In Addition To Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61880	Revision Or Removal Of Intracranial Neurostimulator Electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61885	Insertion Or Replacement Of Cranial Neurostimulator Pulse Generator Or Receiver, Direct Or Inductive Coupling; With Connection To A Single Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61886	Insertion Or Replacement Of Cranial Neurostimulator Pulse Generator Or Receiver, Direct Or Inductive Coupling; With Connection To 2 Or More Electrode Arrays	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
61888	Revision Or Removal Of Cranial Neurostimulator Pulse Generator Or Receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2024	12/31/2999
61891	Revision Or Replacement Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
61892	Removal Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Cranioplasty, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
62263	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg, Hypertonic Saline, Enzyme) Or Mechanical Means (Eg, Catheter) Including Radiologic Localization (Includes Contrast When Administered), Multiple Adhesiolysis Sessions; 2 Or More Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
62264	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg, Hypertonic Saline, Enzyme) Or Mechanical Means (Eg, Catheter) Including Radiologic Localization (Includes Contrast When Administered), Multiple Adhesiolysis Sessions; 1 Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999

62287	Decompression Procedure, Percutaneous, Of Nucleus Pulposus Of Intervertebral Disc, Any Method Utilizing Needle Based Technique To Remove Disc Material Under Fluoroscopic Imaging Or Other Form Of Indirect Visualization, With Discography And/Or Epidural Injection(S) At The Treated Level(S), When Performed, Single Or Multiple Levels, Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
62380	Endoscopic Decompression Of Spinal Cord, Nerve Root(S), Including Laminotomy, Partial Facetectomy, Foraminotomy, Discectomy And/Or Excision Of Herniated Intervertebral Disc, 1 Interspace, Lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
63052	Laminectomy, Facetectomy, Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord, Cauda Equina And/Or Nerve Root[S] [Eg, Spinal Or Lateral Recess Stenosis]), During Posterior Interbody Arthrodesis, Lumbar; Single Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
63053	Laminectomy, Facetectomy, Or Foraminotomy (Unilateral Or Bilateral With Decompression Of Spinal Cord, Cauda Equina And/Or Nerve Root[S] [Eg, Spinal Or Lateral Recess Stenosis]), During Posterior Interbody Arthrodesis, Lumbar; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
64505	Injection, Anesthetic Agent; Sphenopalatine Ganglion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
64553	Percutaneous Implantation Of Neurostimulator Electrode Array; Cranial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
64561	Percutaneous Implantation Of Neurostimulator Electrode Array; Sacral Nerve (Transforaminal Placement) Including Image Guidance, If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
64568	Open Implantation Of Cranial Nerve (Eg, Vagus Nerve) Neurostimulator Electrode Array And Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
64569	Revision Or Replacement Of Cranial Nerve (Eg, Vagus Nerve) Neurostimulator Electrode Array, Including Connection To Existing Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
64570	Removal 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.	11/1/2016	12/31/2999
64581	Open Implantation Of Neurostimulator Electrode Array; Sacral Nerve (Transforaminal Placement)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2022	12/31/2999
64583	Revision Or Replacement Of Hypoglossal Nerve Neurostimulator Array And Distal Respiratory Sensor Electrode Or Electrode Array, Including Connection To Existing Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999

64584	Removal 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.	1/1/2022	12/31/2999
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.	1/1/2024	12/31/2999
64597	Insertion Or Replacement Of Percutaneous Electrode Array, Peripheral Nerve, With Integrated Neurostimulator, Including Imaging Guidance, When Performed; Each Additional Electrode Array (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
64598	Revision Or Removal Of Neurostimulator Electrode Array, Peripheral Nerve, With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
64615	Chemodenervation Of Muscle(S); Muscle(S) Innervated By Facial, Trigeminal, Cervical Spinal And Accessory Nerves, Bilateral (Eg, For Chronic Migraine)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
64625	Radiofrequency Ablation, Nerves Innervating The Sacroiliac Joint, With Image Guidance (Ie, Fluoroscopy Or Computed Tomography)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
64628	Thermal Destruction Of Intraosseous Basivertebral Nerve, Including All Imaging Guidance; First 2 Vertebral Bodies, Lumbar Or Sacral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
64629	Thermal Destruction Of Intraosseous Basivertebral Nerve, Including All Imaging Guidance; Each Additional Vertebral Body, Lumbar Or Sacral (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
64633	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic, Single Facet Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2016	12/31/2999
64634	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging Guidance (Fluoroscopy Or Ct); Cervical Or Thoracic, Each Additional Facet Joint (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2016	12/31/2999
64635	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral, Single Facet Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2016	12/31/2999
64636	Destruction By Neurolytic Agent, Paravertebral Facet Joint Nerve(S), With Imaging Guidance (Fluoroscopy Or Ct); Lumbar Or Sacral, Each Additional Facet Joint (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2016	12/31/2999
64640	Destruction By Neurolytic Agent; Other Peripheral Nerve Or Branch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2019	12/31/2999
64716	Neuroplasty And/Or Transposition; Cranial Nerve (Specify)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

64732	Transection Or Avulsion Of; Supraorbital Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
64734	Transection Or Avulsion Of; Infraorbital Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
64771	Transection Or Avulsion Of Other Cranial Nerve, Extradural	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65710	Keratoplasty (Corneal Transplant); Anterior Lamellar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65730	Keratoplasty (Corneal Transplant); Penetrating (Except In Aphakia Or Pseudophakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65750	Keratoplasty (Corneal Transplant); Penetrating (In Aphakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65755	Keratoplasty (Corneal Transplant); Penetrating (In Pseudophakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65756	Keratoplasty (Corneal Transplant); Endothelial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65757	Backbench Preparation Of Corneal Endothelial Allograft Prior To Transplantation (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
65765	Keratophakia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65771	Radial Keratotomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
65772	Corneal Relaxing Incision For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65775	Corneal Wedge Resection For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
65778	Placement Of Amniotic Membrane On The Ocular Surface; Without Sutures	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2020	12/31/2999

65779	Placement Of Amniotic Membrane On The Ocular Surface; Single Layer, Sutured	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65780	Ocular Surface Reconstruction; Amniotic Membrane Transplantation, Multiple Layers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
65785	Implantation Of Intrastromal Corneal Ring Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
66174	Transluminal Dilation Of Aqueous Outflow Canal (Eg, Canaloplasty); Without Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
66175	Transluminal Dilation Of Aqueous Outflow Canal (Eg, Canaloplasty); With Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
66179	Aqueous Shunt To Extraocular Equatorial Plate Reservoir, External Approach; Without Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
66180	Aqueous Shunt To Extraocular Equatorial Plate Reservoir, External Approach; With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2018	12/31/2999
66183	Insertion Of Anterior Segment Aqueous Drainage Device, Without Extraocular Reservoir, External Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
66184	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; Without Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
66185	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2018	12/31/2999
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.	1/1/2022	12/31/2999
66991	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1 Stage Procedure), Manual Or Mechanical Technique (Eg, Irrigation And Aspiration Or Phacoemulsification); With Insertion Of Intraocular (Eg, Trabecular Meshwork, Supraciliary, Suprachoroidal) Anterior Segment Aqueous Drainage Device, Without Extraocular Reservoir, Internal Approach, One Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
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.	1/1/2013	12/31/2999

67028	Intravitreal Injection Of A Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67345	Chemodenervation Of Extraocular Muscle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	5/1/2024	12/31/2999
67900	Repair Of Brow Ptosis (Supraciliary, Mid-Forehead Or Coronal Approach)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67901	Repair Of Blepharoptosis; Frontalis Muscle Technique With Suture Or Other Material (Eg, Banked Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67902	Repair Of Blepharoptosis; Frontalis Muscle Technique With Autologous Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67903	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement, Internal Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67904	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement, External Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67906	Repair Of Blepharoptosis; Superior Rectus Technique With Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67908	Repair Of Blepharoptosis; Conjunctivo-Tarso-Muller'S Muscle-Levator Resection (Eg, Fasanella-Servat Type)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67909	Reduction Of Overcorrection Of Ptosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67911	Correction Of Lid Retraction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67912	Correction Of Lagophthalmos, With Implantation Of Upper Eyelid Lid Load (Eg, Gold Weight)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67916	Repair Of Ectropion; Excision Tarsal Wedge	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67917	Repair Of Ectropion; Extensive (Eg, Tarsal Strip Operations)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67923	Repair Of Entropion; Excision Tarsal Wedge	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

67924	Repair Of Entropion; Extensive (Eg, Tarsal Strip Or Capsulopalpebral Fascia Repairs Operation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
67950	Canthoplasty (Reconstruction Of Canthus)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
68841	Insertion Of Drug-Eluting Implant, Including Punctal Dilation When Performed, Into Lacrimal Canaliculus, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
69090	Ear Piercing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
69300	Otoplasty, Protruding Ear, With Or Without Size Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
69705	Nasopharyngoscopy, Surgical, With Dilation Of Eustachian Tube (Ie, Balloon Dilation); Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
69706	Nasopharyngoscopy, Surgical, With Dilation Of Eustachian Tube (Ie, Balloon Dilation); Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
69710	Implantation Or Replacement Of Electromagnetic Bone Conduction Hearing Device In Temporal Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
69711	Removal Or Repair Of Electromagnetic Bone Conduction Hearing Device In Temporal Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
69716	Implantation, Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Within The Mastoid And/Or Resulting In Removal Of Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2022	12/31/2999
69726	Removal, Entire 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.	1/1/2022	12/31/2999
69727	Removal, Entire 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.	1/1/2022	12/31/2999

69728	Removal, Entire Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
69729	Implantation, Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside Of The Mastoid And Resulting In Removal Of Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
69730	Replacement (Including Removal Of Existing Device), Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
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.	1/1/2013	12/31/2999
75571	Computed Tomography, Heart, Without Contrast Material, With Quantitative Evaluation Of Coronary Calcium	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	1/1/2013	12/31/2999
76120	Cineradiography/Videoradiography, Except Where Specifically Included	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
76125	Cineradiography/Videoradiography To Complement Routine Examination (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
76940	Ultrasound Guidance For, And Monitoring Of, Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
76948	Ultrasonic Guidance For Aspiration Of Ova, Imaging Supervision And Interpretation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
77013	Computed Tomography Guidance For, And Monitoring Of, Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77022	Magnetic Resonance Imaging Guidance For, And Monitoring Of, Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
77262	Therapeutic Radiology Treatment Planning; Intermediate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77263	Therapeutic Radiology Treatment Planning; Complex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77293	Respiratory Motion Management Simulation (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

77299	Unlisted Procedure, Therapeutic Radiology Clinical Treatment Planning	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77332	Treatment Devices, Design And Construction; Simple (Simple Block, Simple Bolus)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77333	Treatment Devices, Design And Construction; Intermediate (Multiple Blocks, Stents, Bite Blocks, Special Bolus)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77334	Treatment Devices, Design And Construction; Complex (Irregular Blocks, Special Shields, Compensators, Wedges, Molds Or Casts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
77399	Unlisted Procedure, Medical Radiation Physics, Dosimetry And Treatment Devices, And Special Services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
77499	Unlisted Procedure, Therapeutic Radiology Treatment Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
77799	Unlisted Procedure, Clinical Brachytherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
78429	Myocardial Imaging, Positron Emission Tomography (Pet), Metabolic Evaluation Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed), Single Study; With Concurrently Acquired Computed Tomography Transmission Scan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78430	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed); Single Study, At Rest Or Stress (Exercise Or Pharmacologic), With Concurrently Acquired Computed Tomography Transmission Scan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78431	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed); Multiple Studies At Rest And Stress (Exercise Or Pharmacologic), With Concurrently Acquired Computed Tomography Transmission Scan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78432	Myocardial Imaging, Positron Emission Tomography (Pet), Combined Perfusion With Metabolic Evaluation Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed), Dual Radiotracer (Eg, Myocardial Viability);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78433	Myocardial Imaging, Positron Emission Tomography (Pet), Combined Perfusion With Metabolic Evaluation Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed), Dual Radiotracer (Eg, Myocardial Viability); With Concurrently Acquired Computed Tomography Transmission Scan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78434	Absolute Quantitation Of Myocardial Blood Flow (Aqmbf), Positron Emission Tomography (Pet), Rest And Pharmacologic Stress (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
78459	Myocardial Imaging, Positron Emission Tomography (Pet), Metabolic Evaluation Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed), Single Study;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

78491	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed); Single Study, At Rest Or Stress (Exercise Or Pharmacologic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
78492	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion Study (Including Ventricular Wall Motion[S] And/Or Ejection Fraction[S], When Performed); Multiple Studies At Rest And Stress (Exercise Or Pharmacologic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
78835	Radiopharmaceutical Quantification Measurement(S) Single Area (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
79445	Radiopharmaceutical Therapy, By Intra-Arterial Particulate Administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2021	12/31/2999
80145	Adalimumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
80230	Infliximab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
80280	Vedolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
81105	Human Platelet Antigen 1 Genotyping (Hpa-1), Itgb3 (Integrin, Beta 3 [Platelet Glycoprotein Iiia], Antigen Cd61 [Gpiiia]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-1A/B (L33P)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81106	Human Platelet Antigen 2 Genotyping (Hpa-2), Gp1Ba (Glycoprotein Ib [Platelet], Alpha Polypeptide [Gpiba]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-2A/B (T145M)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81107	Human Platelet Antigen 3 Genotyping (Hpa-3), Itga2B (Integrin, Alpha 2B [Platelet Glycoprotein Iib Of Iib/Iiia Complex], Antigen Cd41 [Gpiib]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-3A/B (I843S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81108	Human Platelet Antigen 4 Genotyping (Hpa-4), Itgb3 (Integrin, Beta 3 [Platelet Glycoprotein Iiia], Antigen Cd61 [Gpiiia]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-4A/B (R143Q)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81109	Human Platelet Antigen 5 Genotyping (Hpa-5), Itga2 (Integrin, Alpha 2 [Cd49B, Alpha 2 Subunit Of Vla-2 Receptor] [Gpia]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant (Eg, Hpa-5A/B [K505E])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81110	Human Platelet Antigen 6 Genotyping (Hpa-6W), Itgb3 (Integrin, Beta 3 [Platelet Glycoprotein Iiia, Antigen Cd61] [Gpiiia]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-6A/B (R489Q)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999

81111	Human Platelet Antigen 9 Genotyping (Hpa-9W), Itga2B (Integrin, Alpha 2B [Platelet Glycoprotein Iib Of Iib/Iiia Complex, Antigen Cd41] [Gpiib]) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-9A/B (V837M)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81112	Human Platelet Antigen 15 Genotyping (Hpa-15), Cd109 (Cd109 Molecule) (Eg, Neonatal Alloimmune Thrombocytopenia [Nait], Post-Transfusion Purpura), Gene Analysis, Common Variant, Hpa-15A/B (S682Y)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
81161	Dmd (Dystrophin) (Eg, Duchenne/Becker Muscular Dystrophy) Deletion Analysis, And Duplication Analysis, If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
81206	Bcr/Abl1 (T(9;22)) (Eg, Chronic Myelogenous Leukemia) Translocation Analysis; Major Breakpoint, Qualitative Or Quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
81207	Bcr/Abl1 (T(9;22)) (Eg, Chronic Myelogenous Leukemia) Translocation Analysis; Minor Breakpoint, Qualitative Or Quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
81241	F5 (Coagulation Factor V) (Eg, Hereditary Hypercoagulability) Gene Analysis, Leiden Variant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
81490	Autoimmune (Rheumatoid Arthritis), Analysis Of 12 Biomarkers Using Immunoassays, Utilizing Serum, Prognostic Algorithm Reported As A Disease Activity Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
81500	Oncology (Ovarian), Biochemical Assays Of Two Proteins (Ca-125 And He4), Utilizing Serum, With Menopausal Status, Algorithm Reported As A Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
81507	Fetal Aneuploidy (Trisomy 21, 18, And 13) Dna Sequence Analysis Of Selected Regions Using Maternal Plasma, Algorithm Reported As A Risk Score For Each Trisomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
81538	Oncology (Lung), Mass Spectrometric 8-Protein Signature, Including Amyloid A, Utilizing Serum, Prognostic And Predictive Algorithm Reported As Good Versus Poor Overall Survival	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
81539	Oncology (High-Grade Prostate Cancer), Biochemical Assay Of Four Proteins (Total Psa, Free Psa, Intact Psa, And Human Kallikrein-2 [Hk2]), Utilizing Plasma Or Serum, Prognostic Algorithm Reported As A Probability Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
81560	Transplantation Medicine (Allograft Rejection, Pediatric Liver And Small Bowel), Measurement Of Donor And Third-Party-Induced Cd154+T-Cytotoxic Memory Cells, Utilizing Whole Peripheral Blood, Algorithm Reported As A Rejection Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
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).	2/15/2015	12/31/2999
82777	Galectin-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	1/1/2015	12/31/2999

83695	Lipoprotein (A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
83698	Lipoprotein-Associated Phospholipase A2 (Lp-Pla2)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
83701	Lipoprotein, Blood; High Resolution Fractionation And Quantitation Of Lipoproteins Including Lipoprotein Subclasses When Performed (Eg, Electrophoresis, Ultracentrifugation)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
83704	Lipoprotein, Blood; Quantitation Of Lipoprotein Particle Number(S) (Eg, By Nuclear Magnetic Resonance Spectroscopy), Includes Lipoprotein Particle Subclass(Es), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
83722	Lipoprotein, Direct Measurement; Small Dense Ldl Cholesterol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
83937	Osteocalcin (Bone G1A Protein)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
83987	Ph; Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
84112	Evaluation Of Cervicovaginal Fluid For Specific Amniotic Fluid Protein(S) (Eg, Placental Alpha Microglobulin-1 [Pamg-1], Placental Protein 12 [Pp12], Alpha-Fetoprotein), Qualitative, Each Specimen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2015	12/31/2999
84431	Thromboxane Metabolite(S), Including Thromboxane If Performed, Urine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
86001	Allergen Specific Igg Quantitative Or Semiquantitative, Each Allergen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
86294	Immunoassay For Tumor Antigen, Qualitative Or Semiquantitative (Eg, Bladder Tumor Antigen)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
86328	Immunoassay For Infectious Agent Antibody(Ies), Qualitative Or Semiquantitative, Single-Step Method (Eg, Reagent Strip); Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86343	Leukocyte Histamine Release Test (Lhr)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
86353	Lymphocyte Transformation, Mitogen (Phytomitogen) Or Antigen Induced Blastogenesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
86408	Neutralizing Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Screen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86409	Neutralizing Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Titer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999

86413	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Antibody, Quantitative	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86769	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
86910	Blood Typing, For Paternity Testing, Per Individual; Abo, Rh And Mn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
86911	Blood Typing, For Paternity Testing, Per Individual; Each Additional Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
86950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	5/1/2021	12/31/2999
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.	5/1/2021	12/31/2999
87507	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg, Clostridium Difficile, E. Coli, Salmonella, Shigella, Norovirus, Giardia), Includes Multiplex Reverse Transcription, When Performed, And Multiplex Amplified Probe Technique, Multiple Types Or Subtypes, 12-25 Targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
88000	Necropsy (Autopsy), Gross Examination Only; Without Cns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88005	Necropsy (Autopsy), Gross Examination Only; With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88007	Necropsy (Autopsy), Gross Examination Only; With Brain And Spinal Cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88012	Necropsy (Autopsy), Gross Examination Only; Infant With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88014	Necropsy (Autopsy), Gross Examination Only; Stillborn Or Newborn With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88016	Necropsy (Autopsy), Gross Examination Only; Macerated Stillborn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88020	Necropsy (Autopsy), Gross And Microscopic; Without Cns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88025	Necropsy (Autopsy), Gross And Microscopic; With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88027	Necropsy (Autopsy), Gross And Microscopic; With Brain And Spinal Cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88028	Necropsy (Autopsy), Gross And Microscopic; Infant With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88029	Necropsy (Autopsy), Gross And Microscopic; Stillborn Or Newborn With Brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

88036	Necropsy (Autopsy), Limited, Gross And/Or Microscopic; Regional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88037	Necropsy (Autopsy), Limited, Gross And/Or Microscopic; Single Organ	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88040	Necropsy (Autopsy); Forensic Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
88240	Cryopreservation, Freezing And Storage Of Cells, Each Cell Line	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2016	12/31/2999
88241	Thawing And Expansion Of Frozen Cells, Each Aliquot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2016	12/31/2999
88245	Chromosome Analysis For Breakage Syndromes; Baseline Sister Chromatid Exchange (Sce), 20-25 Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
88248	Chromosome Analysis For Breakage Syndromes; Baseline Breakage, Score 50-100 Cells, Count 20 Cells, 2 Karyotypes (Eg, For Ataxia Telangiectasia, Fanconi Anemia, Fragile X)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
88249	Chromosome Analysis For Breakage Syndromes; Score 100 Cells, Clastogen Stress (Eg, Diepoxybutane, Mitomycin C, Ionizing Radiation, Uv Radiation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
88261	Chromosome Analysis; Count 5 Cells, 1 Karyotype, With Banding	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
88263	Chromosome Analysis; Count 45 Cells For Mosaicism, 2 Karyotypes, With Banding	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
88264	Chromosome Analysis; Analyze 20-25 Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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).	2/15/2015	12/31/2999
89250	Culture Of Oocyte(S)/Embryo(S), Less Than 4 Days;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/15/2022	12/31/2999
89251	Culture Of Oocyte(S)/Embryo(S), Less Than 4 Days; With Co-Culture Of Oocyte(S)/Embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/15/2022	12/31/2999
89253	Assisted Embryo Hatching, Microtechniques (Any Method)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/15/2022	12/31/2999
89254	Oocyte Identification From Follicular Fluid	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89255	Preparation Of Embryo For Transfer (Any Method)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89257	Sperm Identification From Aspiration (Other Than Seminal Fluid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
89258	Cryopreservation; Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89259	Cryopreservation; Sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999

89260	Sperm Isolation; Simple Prep (Eg, Sperm Wash And Swim-Up) For Insemination Or Diagnosis With Semen Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
89261	Sperm Isolation; Complex Prep (Eg, Percoll Gradient, Albumin Gradient) For Insemination Or Diagnosis With Semen Analysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89264	Sperm Identification From Testis Tissue, Fresh Or Cryopreserved	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89268	Insemination Of Oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89272	Extended Culture Of Oocyte(S)/Embryo(S), 4-7 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89280	Assisted Oocyte Fertilization, Microtechnique; Less Than Or Equal To 10 Oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89281	Assisted Oocyte Fertilization, Microtechnique; Greater Than 10 Oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89290	Biopsy, Oocyte Polar Body Or Embryo Blastomere, Microtechnique (For Pre-Implantation Genetic Diagnosis); Less Than Or Equal To 5 Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
89291	Biopsy, Oocyte Polar Body Or Embryo Blastomere, Microtechnique (For Pre-Implantation Genetic Diagnosis); Greater Than 5 Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
89329	Sperm Evaluation; Hamster Penetration Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89330	Sperm Evaluation; Cervical Mucus Penetration Test, With Or Without Spinnbarkeit Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89331	Sperm Evaluation, For Retrograde Ejaculation, Urine (Sperm Concentration, Motility, And Morphology, As Indicated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89335	Cryopreservation, Reproductive Tissue, Testicular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89337	Cryopreservation, Mature Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89342	Storage (Per Year); Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89343	Storage (Per Year); Sperm/Semen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89344	Storage (Per Year); Reproductive Tissue, Testicular/Ovarian	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89346	Storage (Per Year); Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89352	Thawing Of Cryopreserved; Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89353	Thawing Of Cryopreserved; Sperm/Semen, Each Aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89354	Thawing Of Cryopreserved; Reproductive Tissue, Testicular/Ovarian	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
89356	Thawing Of Cryopreserved; Oocytes, Each Aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
90287	Botulinum Antitoxin, Equine, Any Route	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999

90288	Botulism Immune Globulin, Human, For Intravenous Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
90378	Respiratory Syncytial Virus, Monoclonal Antibody, Recombinant, For Intramuscular Use, 50 Mg, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90393	Vaccinia Immune Globulin, Human, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
90476	Adenovirus Vaccine, Type 4, Live, For Oral Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
90477	Adenovirus Vaccine, Type 7, Live, For Oral Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
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.	7/1/2022	12/31/2999
90637	Influenza Virus Vaccine, Quadrivalent (Qirv), Mrna; 30 Mcg/0.5 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2024	12/31/2999
90638	Influenza Virus Vaccine, Quadrivalent (Qirv), Mrna; 60 Mcg/0.5 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2024	12/31/2999
90664	Influenza Virus Vaccine, Live (Laiv), Pandemic Formulation, For Intranasal Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
90676	Rabies Vaccine, For Intradermal Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
90846	Family Psychotherapy (Without The Patient Present), 50 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
90868	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Delivery And Management, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90869	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Motor Threshold Re-Determination With Delivery And Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90875	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient), With Psychotherapy (Eg, Insight Oriented, Behavior Modifying Or Supportive Psychotherapy); 30 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90876	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient), With Psychotherapy (Eg, Insight Oriented, Behavior Modifying Or Supportive Psychotherapy); 45 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90880	Hypnotherapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/1/2024	12/31/2999
90882	Environmental Intervention For Medical Management Purposes On A Psychiatric Patient'S Behalf With Agencies, Employers, Or Institutions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
90885	Psychiatric Evaluation Of Hospital Records, Other Psychiatric Reports, Psychometric And/Or Projective Tests, And Other Accumulated Data For Medical Diagnostic Purposes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

90887	Interpretation Or Explanation Of Results Of Psychiatric, Other Medical Examinations And Procedures, Or Other Accumulated Data To Family Or Other Responsible Persons, Or Advising Them How To Assist Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
90889	Preparation Of Report Of Patient'S Psychiatric Status, History, Treatment, Or Progress (Other Than For Legal Or Consultative Purposes) For Other Individuals, Agencies, Or Insurance Carriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
90901	Biofeedback Training By Any Modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
90912	Biofeedback Training, Perineal Muscles, Anorectal Or Urethral Sphincter, Including Emg And/Or Manometry, When Performed; Initial 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
90913	Biofeedback Training, Perineal Muscles, Anorectal Or Urethral Sphincter, Including Emg And/Or Manometry, When Performed; Each Additional 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
91065	Breath Hydrogen Or Methane Test (Eg, For Detection Of Lactase Deficiency, Fructose Intolerance, Bacterial Overgrowth, Or Oro-Cecal Gastrointestinal Transit)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91110	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Esophagus Through Ileum, With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
91111	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Esophagus With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
91112	Gastrointestinal Transit And Pressure Measurement, Stomach Through Colon, Wireless Capsule, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
91113	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Colon, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

91117	Colon Motility (Manometric) Study, Minimum 6 Hours Continuous Recording (Including Provocation Tests, Eg, Meal, Intracolonic Balloon Distension, Pharmacologic Agents, If Performed), With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2020	12/31/2999
91132	Electrogastrography, Diagnostic, Transcutaneous;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
91133	Electrogastrography, Diagnostic, Transcutaneous; With Provocative Testing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
92066	Orthoptic Training; Under Supervision Of A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
92132	Scanning Computerized Ophthalmic Diagnostic Imaging, Anterior Segment, With Interpretation And Report, Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
92145	Corneal Hysteresis Determination, By Air Impulse Stimulation, Unilateral Or Bilateral, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
92273	Electroretinography (Erg), With Interpretation And Report; Full Field (Ie, Fferg, Flash Erg, Ganzfeld Erg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
92274	Electroretinography (Erg), With Interpretation And Report; Multifocal (Mferg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
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).	2/15/2015	12/31/2999
92517	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And Report; Cervical (Cvemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
92518	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And Report; Ocular (Ovemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
92519	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And Report; Cervical (Cvemp) And Ocular (Ovemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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.	9/1/2020	12/31/2999
92548	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot), 6 Conditions (Ie, Eyes Open, Eyes Closed, Visual Sway, Platform Sway, Eyes Closed Platform Sway, Platform And Visual Sway), Including Interpretation And Report;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
92549	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot), 6 Conditions (Ie, Eyes Open, Eyes Closed, Visual Sway, Platform Sway, Eyes Closed Platform Sway, Platform And Visual Sway), Including Interpretation And Report; With Motor Control Test (Mct) And Adaptation Test (Adt)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

92596	Ear Protector Attenuation Measurements	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92601	Diagnostic Analysis Of Cochlear Implant, Patient Younger Than 7 Years Of Age; With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
92602	Diagnostic Analysis Of Cochlear Implant, Patient Younger Than 7 Years Of Age; Subsequent Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
92603	Diagnostic Analysis Of Cochlear Implant, Age 7 Years Or Older; With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
92604	Diagnostic Analysis Of Cochlear Implant, Age 7 Years Or Older; Subsequent Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
92605	Evaluation For Prescription Of Non-Speech-Generating Augmentative And Alternative Communication Device, Face-To-Face With The Patient; First Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92606	Therapeutic Service(S) For The Use Of Non-Speech-Generating Device, Including Programming And Modification	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92607	Evaluation For Prescription For Speech-Generating Augmentative And Alternative Communication Device, Face-To-Face With The Patient; First Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92608	Evaluation For Prescription For Speech-Generating Augmentative And Alternative Communication Device, Face-To-Face With The Patient; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92609	Therapeutic Services For The Use Of Speech-Generating Device, Including Programming And Modification	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/1/2015	12/31/2999
92618	Evaluation For Prescription Of Non-Speech-Generating Augmentative And Alternative Communication Device, Face-To-Face With The Patient; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
92622	Diagnostic Analysis, Programming, And Verification Of An Auditory Osseointegrated Sound Processor, Any Type; First 60 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92623	Diagnostic Analysis, Programming, And Verification Of An Auditory Osseointegrated Sound Processor, Any Type; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92633	Auditory Rehabilitation; Postlingual Hearing Loss	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
92972	Percutaneous Transluminal Coronary Lithotripsy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92974	Transcatheter Placement Of Radiation Delivery Device For Subsequent Coronary Intravascular Brachytherapy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

92978	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision, Interpretation And Report; Initial 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.	9/1/2020	12/31/2999
92979	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision, Interpretation And Report; 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.	9/1/2020	12/31/2999
93025	Microvolt T-Wave Alternans For Assessment Of Ventricular Arrhythmias	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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).	5/1/2016	12/31/2999
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System, Including All Interrogation And Programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93152	Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93153	Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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.	1/1/2020	12/31/2999
93229	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording, Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center For Up To 30 Days; Technical Support For Connection And Patient Instructions For Use, Attended Surveillance, Analysis And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

93260	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; Implantable Subcutaneous Lead Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
93261	Interrogation Device Evaluation (In Person) With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional, Includes Connection, Recording And Disconnection Per Patient Encounter; Implantable Subcutaneous Lead Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
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.	9/1/2020	12/31/2999
93278	Signal-Averaged Electrocardiography (Saecg), With Or Without Ecg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2018	12/31/2999
93282	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; Single Lead Transvenous Implantable Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93283	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; Dual Lead Transvenous Implantable Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2016	12/31/2999
93284	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; Multiple Lead Transvenous Implantable Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93285	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; Subcutaneous Cardiac Rhythm Monitor System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
93287	Peri-Procedural Device Evaluation (In Person) And Programming Of Device System Parameters Before Or After A Surgery, Procedure, Or Test With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional; Single, Dual, Or Multiple Lead Implantable Defibrillator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93289	Interrogation Device Evaluation (In Person) With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional, Includes Connection, Recording And Disconnection Per Patient Encounter; Single, Dual, Or Multiple Lead Transvenous Implantable Defibrillator System, Including Analysis Of Heart Rhythm Derived Data Elements	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

93290	Interrogation Device Evaluation (In Person) With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional, Includes Connection, Recording And Disconnection Per Patient Encounter; Implantable Cardiovascular Physiologic Monitor System, Including Analysis Of 1 Or More Recorded Physiologic Cardiovascular Data Elements From All Internal And External Sensors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
93291	Interrogation Device Evaluation (In Person) With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional, Includes Connection, Recording And Disconnection Per Patient Encounter; Subcutaneous Cardiac Rhythm Monitor System, Including Heart Rhythm Derived Data Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
93295	Interrogation Device Evaluation(S) (Remote), Up To 90 Days; Single, Dual, Or Multiple Lead Implantable Defibrillator System With Interim Analysis, Review(S) 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.	1/1/2013	12/31/2999
93296	Interrogation Device Evaluation(S) (Remote), Up To 90 Days; Single, Dual, Or Multiple Lead Pacemaker System, Leadless Pacemaker System, Or Implantable Defibrillator System, Remote Data Acquisition(S), Receipt Of Transmissions And Technician Review, Technical Support And Distribution Of Results	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93297	Interrogation Device Evaluation(S), (Remote) Up To 30 Days; Implantable Cardiovascular Physiologic Monitor System, Including Analysis Of 1 Or More Recorded Physiologic Cardiovascular Data Elements From All Internal And External Sensors, Analysis, Review(S) 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.	9/15/2016	12/31/2999
93298	Interrogation Device Evaluation(S), (Remote) Up To 30 Days; Subcutaneous Cardiac Rhythm Monitor System, Including Analysis Of Recorded Heart Rhythm Data, Analysis, Review(S) 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.	9/15/2016	12/31/2999
93356	Myocardial Strain Imaging Using Speckle Tracking-Derived Assessment Of Myocardial Mechanics (List Separately In Addition To Codes For Echocardiography Imaging)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
93580	Percutaneous Transcatheter Closure Of Congenital Interatrial Communication (Ie, Fontan Fenestration, Atrial Septal Defect) With Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93640	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination) At Time Of Initial Implantation Or Replacement;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93641	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination) At Time Of Initial Implantation Or Replacement; With Testing Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

93642	Electrophysiologic Evaluation Of Single Or Dual Chamber Transvenous Pacing Cardioverter-Defibrillator (Includes Defibrillation Threshold Evaluation, Induction Of Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination, And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93644	Electrophysiologic Evaluation Of Subcutaneous Implantable Defibrillator (Includes Defibrillation Threshold Evaluation, Induction Of Arrhythmia, Evaluation Of Sensing For Arrhythmia Termination, And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
93660	Evaluation Of Cardiovascular Function With Tilt Table Evaluation, With Continuous Ecg Monitoring And Intermittent Blood Pressure Monitoring, With Or Without Pharmacological Intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93668	Peripheral Arterial Disease (Pad) Rehabilitation, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
93701	Bioimpedance-Derived Physiologic Cardiovascular Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
93702	Bioimpedance Spectroscopy (Bis), Extracellular Fluid Analysis For Lymphedema Assessment(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
93750	Interrogation Of Ventricular Assist Device (Vad), In Person, With Physician Or Other Qualified Health Care Professional Analysis Of Device Parameters (Eg, Drivelines, Alarms, Power Surges), Review Of Device Function (Eg, Flow And Volume Status, Septum Status, Recovery), With Programming, If Performed, And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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).	2/15/2015	12/31/2999
94015	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Recording (Includes Hook-Up, Reinforced Education, Data Transmission, Data Capture, Trend Analysis, And Periodic Recalibration)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
94016	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Review And Interpretation Only By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
94452	High Altitude Simulation Test (Hast), With Interpretation And Report By A Physician Or Other Qualified Health Care Professional;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
94453	High Altitude Simulation Test (Hast), With Interpretation And Report By A Physician Or Other Qualified Health Care Professional; With Supplemental Oxygen Titration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
94669	Mechanical Chest Wall Oscillation To Facilitate Lung Function, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

95027	Intracutaneous (Intradermal) Tests, Sequential And Incremental, With Allergenic Extracts For Airborne Allergens, Immediate Type Reaction, Including Test Interpretation And Report, Specify Number Of Tests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95060	Ophthalmic Mucous Membrane Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
95065	Direct Nasal Mucous Membrane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
95249	Ambulatory Continuous Glucose Monitoring Of Interstitial Tissue Fluid Via A Subcutaneous Sensor For A Minimum Of 72 Hours; Patient-Provided Equipment, Sensor Placement, Hook-Up, Calibration Of Monitor, Patient Training, And Printout Of Recording	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
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.	1/1/2020	12/31/2999
95705	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95706	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95707	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; With Continuous, Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95708	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95709	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95710	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, Each Increment Of 12-26 Hours; With Continuous, Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95711	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95712	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95713	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; With Continuous, Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95714	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description By Eeg Technologist, Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95715	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description By Eeg Technologist, Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

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.	1/1/2020	12/31/2999
95717	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation And Report, 2-12 Hours Of Eeg Recording; Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95718	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation And Report, 2-12 Hours Of Eeg Recording; With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95719	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Each Increment Of Greater Than 12 Hours, Up To 26 Hours Of Eeg Recording, Interpretation And Report After Each 24-Hour Period; Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95720	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Each Increment Of Greater Than 12 Hours, Up To 26 Hours Of Eeg Recording, Interpretation And Report After Each 24-Hour Period; With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95721	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater Than 36 Hours, Up To 60 Hours Of Eeg Recording, Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95722	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater Than 36 Hours, Up To 60 Hours Of Eeg Recording, With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95723	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater Than 60 Hours, Up To 84 Hours Of Eeg Recording, Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95724	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater Than 60 Hours, Up To 84 Hours Of Eeg Recording, With Video (Veeg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
95725	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified Health Care Professional Review Of Recorded Events, Analysis Of Spike And Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater Than 84 Hours Of Eeg Recording, Without Video	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

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.	1/1/2020	12/31/2999
95782	Polysomnography; Younger Than 6 Years, Sleep Staging With 4 Or More Additional Parameters Of Sleep, Attended By A Technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2021	12/31/2999
95783	Polysomnography; Younger Than 6 Years, Sleep Staging With 4 Or More Additional Parameters Of Sleep, With Initiation Of Continuous Positive Airway Pressure Therapy Or Bi-Level Ventilation, Attended By A Technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2021	12/31/2999
95803	Actigraphy Testing, Recording, Analysis, Interpretation, And Report (Minimum Of 72 Hours To 14 Consecutive Days Of Recording)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
95805	Multiple Sleep Latency Or Maintenance Of Wakefulness Testing, Recording, Analysis And Interpretation Of Physiological Measurements Of Sleep During Multiple Trials To Assess Sleepiness	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95836	Electrocorticogram From An Implanted Brain Neurostimulator Pulse Generator/Transmitter, Including Recording, With Interpretation And Written Report, Up To 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
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).	2/15/2015	12/31/2999
95919	Quantitative Pupillometry With Physician Or Other Qualified Health Care Professional Interpretation And Report, Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
95921	Testing Of Autonomic Nervous System Function; Cardiovagal Innervation (Parasympathetic Function), Including 2 Or More Of The Following: Heart Rate Response To Deep Breathing With Recorded R-R Interval, Valsalva Ratio, And 30:15 Ratio	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
95922	Testing Of Autonomic Nervous System Function; Vasomotor Adrenergic Innervation (Sympathetic Adrenergic Function), Including Beat-To-Beat Blood Pressure And R-R Interval Changes During Valsalva Maneuver And At Least 5 Minutes Of Passive Tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
95923	Testing Of Autonomic Nervous System Function; Sudomotor, Including 1 Or More Of The Following: Quantitative Sudomotor Axon Reflex Test (Qsart), Silastic Sweat Imprint, Thermoregulatory Sweat Test, And Changes In Sympathetic Skin Potential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
95924	Testing Of Autonomic Nervous System Function; Combined Parasympathetic And Sympathetic Adrenergic Function Testing With At Least 5 Minutes Of Passive Tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
95925	Short-Latency Somatosensory Evoked Potential Study, Stimulation Of Any/All Peripheral Nerves Or Skin Sites, Recording From The Central Nervous System; In Upper Limbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95926	Short-Latency Somatosensory Evoked Potential Study, Stimulation Of Any/All Peripheral Nerves Or Skin Sites, Recording From The Central Nervous System; In Lower Limbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

95927	Short-Latency Somatosensory Evoked Potential Study, Stimulation Of Any/All Peripheral Nerves Or Skin Sites, Recording From The Central Nervous System; In The Trunk Or Head	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95930	Visual Evoked Potential (Vep) Checkerboard Or Flash Testing, Central Nervous System Except Glaucoma, With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95938	Short-Latency Somatosensory Evoked Potential Study, Stimulation Of Any/All Peripheral Nerves Or Skin Sites, Recording From The Central Nervous System; In Upper And Lower Limbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
95954	Pharmacological Or Physical Activation Requiring Physician Or Other Qualified Health Care Professional Attendance During Eeg Recording Of Activation Phase (Eg, Thiopental Activation Test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2014	12/31/2999
95957	Digital Analysis Of Electroencephalogram (Eeg) (Eg, For Epileptic Spike Analysis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
95961	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface, Or Of Depth Electrodes, To Provoke Seizures Or Identify Vital Brain Structures; Initial Hour Of Attendance By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2015	12/31/2999
95962	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface, Or Of Depth Electrodes, To Provoke Seizures Or Identify Vital Brain Structures; Each Additional Hour Of Attendance By A Physician Or Other Qualified Health Care Professional (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2015	12/31/2999
95965	Magnetoencephalography (Meg), Recording And Analysis; For Spontaneous Brain Magnetic Activity (Eg, Epileptic Cerebral Cortex Localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95966	Magnetoencephalography (Meg), Recording And Analysis; For Evoked Magnetic Fields, Single Modality (Eg, Sensory, Motor, Language, Or Visual Cortex Localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
95976	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz], On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop Parameters, And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Simple Cranial Nerve Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999

95977	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz], On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop Parameters, And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Complex Cranial Nerve Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
95980	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; Intraoperative, With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95981	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg, Rate, Pulse Amplitude And Duration, Configuration Of Wave Form, Battery Status, Electrode Selectability, Output Modulation, Cycling, Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent, Without Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95982	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg, Rate, Pulse Amplitude And Duration, Configuration Of Wave Form, Battery Status, Electrode Selectability, Output Modulation, Cycling, Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent, With Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
95999	Unlisted Neurological Or Neuromuscular Diagnostic Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
96001	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics; With Dynamic Plantar Pressure Measurements During Walking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96002	Dynamic Surface Electromyography, During Walking Or Other Functional Activities, 1-12 Muscles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96003	Dynamic Fine Wire Electromyography, During Walking Or Other Functional Activities, 1 Muscle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96004	Review And Interpretation By Physician Or Other Qualified Health Care Professional Of Comprehensive Computer-Based Motion Analysis, Dynamic Plantar Pressure Measurements, Dynamic Surface Electromyography During Walking Or Other Functional Activities, And Dynamic Fine Wire Electromyography, With Written Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

96547	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure, Including Separate Incision(S) And Closure, When Performed; First 60 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
96548	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure, Including Separate Incision(S) And Closure, When Performed; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
96570	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal Tissue Via Activation Of Photosensitive Drug(S); First 30 Minutes (List Separately In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of Lung And Gastrointestinal Tract)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96571	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal Tissue Via Activation Of Photosensitive Drug(S); Each Additional 15 Minutes (List Separately In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of Lung And Gastrointestinal Tract)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96912	Photochemotherapy; Psoralens And Ultraviolet A (Puva)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96913	Photochemotherapy (Goeckerman And/Or Puva) For Severe Photoresponsive Dermatoses Requiring At Least 4-8 Hours Of Care Under Direct Supervision Of The Physician (Includes Application Of Medication And Dressings)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
96920	Excimer Laser Treatment For Psoriasis; Total Area Less Than 250 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2021	12/31/2999
96921	Excimer Laser Treatment For Psoriasis; 250 Sq Cm To 500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2021	12/31/2999
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.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999

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.	9/1/2020	12/31/2999
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.	1/1/2024	12/31/2999
97150	Therapeutic Procedure(S), Group (2 Or More Individuals)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
97545	Work Hardening/Conditioning; Initial 2 Hours	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
97546	Work Hardening/Conditioning; Each Additional Hour (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
97605	Negative Pressure Wound Therapy (Eg, Vacuum Assisted Drainage Collection), Utilizing Durable Medical Equipment (Dme), Including Topical Application(S), Wound Assessment, And Instruction(S) For Ongoing Care, Per Session; Total Wound(S) Surface Area Less Than Or Equal To 50 Square Centimeters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
97606	Negative Pressure Wound Therapy (Eg, Vacuum Assisted Drainage Collection), Utilizing Durable Medical Equipment (Dme), Including Topical Application(S), Wound Assessment, And Instruction(S) For Ongoing Care, Per Session; Total Wound(S) Surface Area Greater Than 50 Square Centimeters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
97607	Negative Pressure Wound Therapy, (Eg, Vacuum Assisted Drainage Collection), Utilizing Disposable, Non-Durable Medical Equipment Including Provision Of Exudate Management Collection System, Topical Application(S), Wound Assessment, And Instructions For Ongoing Care, Per Session; Total Wound(S) Surface Area Less Than Or Equal To 50 Square Centimeters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
97608	Negative Pressure Wound Therapy, (Eg, Vacuum Assisted Drainage Collection), Utilizing Disposable, Non-Durable Medical Equipment Including Provision Of Exudate Management Collection System, Topical Application(S), Wound Assessment, And Instructions For Ongoing Care, Per Session; Total Wound(S) Surface Area Greater Than 50 Square Centimeters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
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).	2/15/2015	12/31/2999
99071	Educational Supplies, Such As Books, Tapes, And Pamphlets, For The Patient'S Education At Cost To Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2016	12/31/2999
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2016	12/31/2999

99080	Special Reports Such As Insurance Forms, More Than The Information Conveyed In The Usual Medical Communications Or Standard Reporting Form	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2016	12/31/2999
99082	Unusual Travel (Eg, Transportation And Escort Of Patient)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
99174	Instrument-Based Ocular Screening (Eg, Photoscreening, Automated-Refraction), Bilateral; With Remote Analysis And Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
99177	Instrument-Based Ocular Screening (Eg, Photoscreening, Automated-Refraction), Bilateral; With On-Site Analysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
99183	Physician Or Other Qualified Health Care Professional Attendance And Supervision Of Hyperbaric Oxygen Therapy, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
99500	Home Visit For Prenatal Monitoring And Assessment To Include Fetal Heart Rate, Non-Stress Test, Uterine Monitoring, And Gestational Diabetes Monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2020	12/31/2999
99506	Home Visit For Intramuscular Injections	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
99509	Home Visit For Assistance With Activities Of Daily Living And Personal Care	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
99512	Home Visit For Hemodialysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
0024U	Glycosylated Acute Phase Proteins (Glyca), Nuclear Magnetic Resonance Spectroscopy, Quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
0025U	Tenofovir, By Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms), Urine, Quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
0052U	Lipoprotein, Blood, High Resolution Fractionation And Quantitation Of Lipoproteins, Including All Five Major Lipoprotein Classes And Subclasses Of Hdl, Ldl, And Vldl By Vertical Auto Profile Ultracentrifugation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2018	12/31/2999
0054T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure, With Image-Guidance Based On Fluoroscopic Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0055T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure, With Image-Guidance Based On Ct/Mri Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2015	12/31/2999
0062U	Autoimmune (Systemic Lupus Erythematosus), Igg And Igm Analysis Of 80 Biomarkers, Utilizing Serum, Algorithm Reported With A Risk Score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0063U	Neurology (Autism), 32 Amines By Lc-Ms/Ms, Using Plasma, Algorithm Reported As Metabolic Signature Associated With Autism Spectrum Disorder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0067U	Oncology (Breast), Immunohistochemistry, Protein Expression Profiling Of 4 Biomarkers (Matrix Metalloproteinase-1 [Mmp-1], Carcinoembryonic Antigen-Related Cell Adhesion Molecule 6 [Ceacam6], Hyaluronoglucosaminidase [Hyal1], Highly Expressed In Cancer Protein [Hec1]), Formalin-Fixed Paraffin-Embedded Precancerous Breast Tissue, Algorithm Reported As Carcinoma Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
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.	9/1/2020	12/31/2999
0072T	Focused Ultrasound Ablation Of Uterine Leiomyomata, Including Mr Guidance; Total Leiomyomata Volume Greater Or Equal To 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0075T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S), Including Radiologic Supervision And Interpretation, Open Or Percutaneous; Initial Vessel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
0076T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S), Including Radiologic Supervision And Interpretation, Open Or Percutaneous; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
0101T	Extracorporeal Shock Wave Involving Musculoskeletal System, Not Otherwise Specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0102T	Extracorporeal Shock Wave Performed By A Physician, Requiring Anesthesia Other Than Local, And Involving The Lateral Humeral Epicondyle	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0105U	Nephrology (Chronic Kidney Disease), Multiplex Electrochemiluminescent Immunoassay (Eclia) Of Tumor Necrosis Factor Receptor 1A, Receptor Superfamily 2 (Tnfr1, Tnfr2), And Kidney Injury Molecule-1 (Kim-1) Combined With Longitudinal Clinical Data, Including Apol1 Genotype If Available, And Plasma (Isolated Fresh Or Frozen), Algorithm Reported As Probability Score For Rapid Kidney Function Decline (Rkfd)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
0106T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Touch Pressure Stimuli To Assess Large Diameter Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0106U	Gastric Emptying, Serial Collection Of 7 Timed Breath Specimens, Non-Radioisotope Carbon-13 (13C) Spirulina Substrate, Analysis Of Each Specimen By Gas Isotope Ratio Mass Spectrometry, Reported As Rate Of 13Co2 Excretion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0107T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Vibration Stimuli To Assess Large Diameter Fiber Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0108T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Cooling Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0109T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Heat-Pain Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999

0110T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Other Stimuli To Assess Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0119U	Cardiology, Ceramides By Liquid Chromatography?Tandem Mass Spectrometry, Plasma, Quantitative Report With Risk Score For Major Cardiovascular Events	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0164U	Gastroenterology (Irritable Bowel Syndrome [Ibs]), Immunoassay For Anti-Cdtb And Anti-Vinculin Antibodies, Utilizing Plasma, Algorithm For Elevated Or Not Elevated Qualitative Results	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0165U	Peanut Allergen-Specific Quantitative Assessment Of Multiple Epitopes Using Enzyme-Linked Immunosorbent Assay (Elisa), Blood, Individual Epitope Results And Probability Of Peanut Allergy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
0172U	Oncology (Solid Tumor As Indicated By The Label), Somatic Mutation Analysis Of Brca1 (Brca1, Dna Repair Associated), Brca2 (Brca2, Dna Repair Associated) And Analysis Of Homologous Recombination Deficiency Pathways, Dna, Formalin-Fixed Paraffin-Embedded Tissue, Algorithm Quantifying Tumor Genomic Instability Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
0173U	Psychiatry (Ie, Depression, Anxiety), Genomic Analysis Panel, Includes Variant Analysis Of 14 Genes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
0175U	Psychiatry (Eg, Depression, Anxiety), Genomic Analysis Panel, Variant Analysis Of 15 Genes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
0176U	Cytolethal Distending Toxin B (Cdtb) And Vinculin Igg Antibodies By Immunoassay (Ie, Elisa)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0178U	Peanut Allergen-Specific Quantitative Assessment Of Multiple Epitopes Using Enzyme-Linked Immunosorbent Assay (Elisa), Blood, Report Of Minimum Eliciting Exposure For A Clinical Reaction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0198T	Measurement Of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0200T	Percutaneous Sacral Augmentation (Sacroplasty), Unilateral Injection(S), Including The Use Of A Balloon Or Mechanical Device, When Used, 1 Or More Needles, Includes Imaging Guidance And Bone Biopsy, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0201T	Percutaneous Sacral Augmentation (Sacroplasty), Bilateral Injections, Including The Use Of A Balloon Or Mechanical Device, When Used, 2 Or More Needles, Includes Imaging Guidance And Bone Biopsy, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0202T	Posterior Vertebral Joint(S) Arthroplasty (Eg, Facet Joint[S] Replacement), Including Facetectomy, Laminectomy, Foraminotomy, And Vertebral Column Fixation, Injection Of Bone Cement, When Performed, Including Fluoroscopy, Single Level, Lumbar Spine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0207T	Evacuation Of Meibomian Glands, Automated, Using Heat And Intermittent Pressure, Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0213T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Cervical Or Thoracic; Single Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0214T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Cervical Or Thoracic; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0215T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Cervical Or Thoracic; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0216T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Lumbar Or Sacral; Single Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0217T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Lumbar Or Sacral; Second Level (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0218T	Injection(S), Diagnostic Or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (Or Nerves Innervating That Joint) With Ultrasound Guidance, Lumbar Or Sacral; Third And Any Additional Level(S) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0219T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level; Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0220T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level; Thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0221T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level; Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0222T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0224U	Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]), Includes Titer(S), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
0226U	Surrogate Viral Neutralization Test (Svnt), Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]), Elisa, Plasma, Seru	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
0232T	Injection(S), Platelet Rich Plasma, Any Site, Including Image Guidance, Harvesting And Preparation When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0253T	Insertion Of Anterior Segment Aqueous Drainage Device, Without Extraocular Reservoir, Internal Approach, Into The Suprachoroidal Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
0255U	Andrology (Infertility), Sperm-Capacitation Assessment Of Ganglioside Gm1 Distribution Patterns, Fluorescence Microscopy, Fresh Or Frozen Specimen, Reported As Percentage Of Capacitated Sperm And Probability Of Generating A Pregnancy Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999

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).	2/15/2015	12/31/2999
0263U	Neurology (Autism Spectrum Disorder [Asd]), Quantitative Measurements Of 16 Central Carbon Metabolites (Ie, ?-Ketoglutarate, Alanine, Lactate, Phenylalanine, Pyruvate, Succinate, Carnitine, Citrate, Fumarate, Hypoxanthine, Inosine, Malate, S-Sulfocysteine, Taurine, Urate, And Xanthine), Liquid Chromatography Tandem Mass Spectrometry (Lc-Ms/Ms), Plasma, Algorithmic Analysis With Result Reported As Negative Or Positive (With Metabolic Subtypes Of Asd)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
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).	2/15/2015	12/31/2999
0265T	Intramuscular Autologous Bone Marrow Cell Therapy, With Preparation Of Harvested Cells, Multiple Injections, One Leg, Including Ultrasound Guidance, If Performed; Unilateral Or Bilateral Bone Marrow Harvest Only For Intramuscular Autologous Bone Marrow Cell Therapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0266T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement, Unilateral Or Bilateral Lead Placement, Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0267T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Lead Only, Unilateral (Includes Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0268T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0269T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement, Unilateral Or Bilateral Lead Placement, Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0270T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Lead Only, Unilateral (Includes Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0271T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0272T	Interrogation Device Evaluation (In Person), Carotid Sinus Baroreflex Activation System, Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values, With Interpretation And Report (Eg, Battery Status, Lead Impedance, Pulse Amplitude, Pulse Width, Therapy Frequency, Pathway Mode, Burst Mode, Therapy Start/Stop Times Each Day);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0273T	Interrogation Device Evaluation (In Person), Carotid Sinus Baroreflex Activation System, Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values, With Interpretation And Report (Eg, Battery Status, Lead Impedance, Pulse Amplitude, Pulse Width, Therapy Frequency, Pathway Mode, Burst Mode, Therapy Start/Stop Times Each Day); With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements, (With Or Without Ligamentous Resection, Discectomy, Facetectomy And/Or Foraminotomy), Any Method, Under Indirect Image Guidance (Eg, Fluoroscopic, Ct), Single Or Multiple Levels, Unilateral Or Bilateral; Cervical Or Thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements, (With Or Without Ligamentous Resection, Discectomy, Facetectomy And/Or Foraminotomy), Any Method, Under Indirect Image Guidance (Eg, Fluoroscopic, Ct), Single Or Multiple Levels, Unilateral Or Bilateral; Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg, Scrambler Therapy), Each Treatment Session (Includes Placement Of Electrodes)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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.	1/1/2013	12/31/2999
0312U	Autoimmune Diseases (Eg, Systemic Lupus Erythematosus [Sle]), Analysis Of 8 Igg Autoantibodies And 2 Cell-Bound Complement Activation Products Using Enzyme-Linked Immunosorbent Immunoassay (Elisa), Flow Cytometry And Indirect Immunofluorescence, Serum, Or Plasma And Whole Blood, Individual Components Reported Along With An Algorithmic Sle-Likelihood Assessment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
0316U	Borrelia Burgdorferi (Lyme Disease), Ospa Protein Evaluation, Urine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
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).	2/1/2024	12/31/2999
0329T	Monitoring Of Intraocular Pressure For 24 Hours Or Longer, Unilateral Or Bilateral, With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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).	2/15/2015	12/31/2999
0331T	Myocardial Sympathetic Innervation Imaging, Planar Qualitative And Quantitative Assessment;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0332T	Myocardial Sympathetic Innervation Imaging, Planar Qualitative And Quantitative Assessment; With Tomographic Spect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0335T	Insertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0338T	Transcatheter Renal Sympathetic Denervation, Percutaneous Approach Including Arterial Puncture, Selective Catheter Placement(S) Renal Artery(Ies), Fluoroscopy, Contrast Injection(S), Intraprocedural Roadmapping And Radiological Supervision And Interpretation, Including Pressure Gradient Measurements, Flush Aortogram And Diagnostic Renal Angiography When Performed; Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0338U	Oncology (Solid Tumor), Circulating Tumor Cell Selection, Identification, Morphological Characterization, Detection And Enumeration Based On Differential Epcam, Cytokeratins 8, 18, And 19, And Cd45 Protein Biomarkers, And Quantification Of Her2 Protein Biomarker?Expressing Cells, Peripheral Blood	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
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).	2/15/2015	12/31/2999
0342T	Therapeutic Apheresis With Selective Hdl Delipidation And Plasma Reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach Via The Coronary Sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
0346U	Beta Amyloid, A?40 And A?42 By Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms), Ratio, Plasma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
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).	2/15/2015	12/31/2999
0348T	Radiologic Examination, Radiostereometric Analysis (Rsa); Spine, (Includes Cervical, Thoracic And Lumbosacral, When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0349T	Radiologic Examination, Radiostereometric Analysis (Rsa); Upper Extremity(Ies), (Includes Shoulder, Elbow, And Wrist, When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0350T	Radiologic Examination, Radiostereometric Analysis (Rsa); Lower Extremity(Ies), (Includes Hip, Proximal Femur, Knee, And Ankle, When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
0351T	Optical Coherence Tomography Of Breast Or Axillary Lymph Node, Excised Tissue, Each Specimen; Real-Time Intraoperative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
0353T	Optical Coherence Tomography Of Breast, Surgical Cavity; Real-Time Intraoperative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

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.	9/1/2020	12/31/2999
0358T	Bioelectrical Impedance Analysis Whole Body Composition Assessment, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna), Gastrointestinal Pathogens, 31 Bacterial, Viral, And Parasitic Organisms And Identification Of 21 Associated Antibiotic-Resistance Genes, Multiplex Amplified Probe Technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0378T	Visual Field Assessment, With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Review And Interpretation With Report By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0379T	Visual Field Assessment, With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Technical Support And Patient Instructions, Surveillance, Analysis, And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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).	1/1/2016	12/31/2999
0398T	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (Mrgfus), Stereotactic Ablation Lesion, Intracranial For Movement Disorder Including Stereotactic Navigation And Frame Placement When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2019	12/31/2999
0402T	Collagen Cross-Linking Of Cornea, Including Removal Of The Corneal Epithelium, When Performed, And Intraoperative Pachymetry, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
0405U	Oncology (Pancreatic), 59 Methylation Haplotype Block Markers, Next-Generation Sequencing, Plasma, Reported As Cancer Signal Detected Or Not Detected	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
0407U	Nephrology (Diabetic Chronic Kidney Disease [Ckd]), Multiplex Electrochemiluminescent Immunoassay (Eclia) Of Soluble Tumor Necrosis Factor Receptor 1 (Stnfr1), Soluble Tumor Necrosis Receptor 2 (Stnfr2), And Kidney Injury Molecule 1 (Kim-1) Combined With Clinical Data, Plasma, Algorithm Reported As Risk For Progressive Decline In Kidney Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
0408T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System, Including Contractility Evaluation When Performed, And Programming Of Sensing And Therapeutic Parameters; Pulse Generator With Transvenous Electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999

0410T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System, Including Contractility Evaluation When Performed, And Programming Of Sensing And Therapeutic Parameters; Atrial Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0410U	Oncology (Pancreatic), Dna, Whole Genome Sequencing With 5-Hydroxymethylcytosine Enrichment, Whole Blood Or Plasma, Algorithm Reported As Cancer Detected Or Not Detected	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	9/1/2020	12/31/2999
0411U	Psychiatry (Eg, Depression, Anxiety, Attention Deficit Hyperactivity Disorder [Adhd]), Genomic Analysis Panel, Variant Analysis Of 15 Genes, Including Deletion/Duplication Analysis Of Cyp2D6	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	9/1/2020	12/31/2999
0412U	Beta Amyloid, A?42/40 Ratio, Immunoprecipitation With Quantitation By Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) And Qualitative Apoe Isoformspecific Proteotyping, Plasma Combined With Age, Algorithm Reported As Presence Or Absence Of Brain Amyloid Pathology	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	9/1/2020	12/31/2999
0413U	Oncology (Hematolymphoid Neoplasm), Optical Genome Mapping For Copy Number Alterations, Aneuploidy, And Balanced/Complex Structural Rearrangements, Dna From Blood Or Bone Marrow, Report Of Clinically Significant Alterations	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	9/1/2020	12/31/2999
0415T	Repositioning Of Previously Implanted Cardiac Contractility Modulation Transvenous Electrode (Atrial Or Ventricular Lead)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0416T	Relocation Of Skin Pocket For Implanted Cardiac Contractility Modulation Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0417T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis, Including Review And Report, Implantable Cardiac Contractility Modulation System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0417U	Rare Diseases (Constitutional/Heritable Disorders), Whole Mitochondrial Genome Sequence With Heteroplasmy Detection And Deletion Analysis, Nuclear-Encoded Mitochondrial Gene Analysis Of 335 Nuclear Genes, Including Sequence Changes, Deletions, Insertions, And Copy Number Variants Analysis, Blood Or Saliva, Identification And Categorization Of Mitochondrial Disorder?Associated Genetic Variants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999

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.	9/1/2020	12/31/2999
0419U	Neuropsychiatry (Eg, Depression, Anxiety), Genomic Sequence Analysis Panel, Variant Analysis Of 13 Genes, Saliva Or Buccal Swab, Report Of Each Gene Phenotype	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	9/1/2020	12/31/2999
0436U	Oncology (Lung), Plasma Analysis Of 388 Proteins, Using Aptamerbased Proteomics Technology, Predictive Algorithm Reported As Clinical Benefit From Immune Checkpoint Inhibitor Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
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.	9/1/2020	12/31/2999
0441T	Ablation, Percutaneous, Cryoablation, Includes Imaging Guidance; Lower Extremity Distal/Peripheral Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0442T	Ablation, Percutaneous, Cryoablation, Includes Imaging Guidance; Nerve Plexus Or Other Truncal Nerve (Eg, Brachial Plexus, Pudendal Nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0443T	Real-Time Spectral Analysis Of Prostate Tissue By Fluorescence Spectroscopy, Including Imaging Guidance (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0446U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]), Analysis Of 10 Cytokine Soluble Mediator Biomarkers By Immunoassay, Plasma, Individual Components Reported With An Algorithmic Risk Score For Current Disease Activity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
0447U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]), Analysis Of 11 Cytokine Soluble Mediator Biomarkers By Immunoassay, Plasma, Individual Components Reported With An Algorithmic Prognostic Risk Score For Developing A Clinical Flare	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
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.	9/15/2019	12/31/2999
0450T	Insertion Of Aqueous Drainage Device, Without Extraocular Reservoir, Internal Approach, Into The Subconjunctival Space; Each Additional Device (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2019	12/31/2999
0462U	Melatonin Levels Test, Sleep Study, 7 Or 9 Sample Melatonin Profile (Cortisol Optional), Enzyme-Linked Immunosorbent Assay (Elisa), Saliva, Screening/Preliminary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0464T	Visual Evoked Potential, Testing For Glaucoma, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0469T	Retinal Polarization Scan, Ocular Screening With On-Site Automated Results, Bilateral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2017	12/31/2999
0474T	Insertion Of Anterior Segment Aqueous Drainage Device, With Creation Of Intraocular Reservoir, Internal Approach, Into The Supraciliary Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2017	12/31/2999

0479T	Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; First 100 Cm2 Or Part Thereof, Or 1% Of Body Surface Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0480T	Fractional Ablative Laser Fenestration Of Burn And Traumatic Scars For Functional Improvement; Each Additional 100 Cm2, Or Each Additional 1% Of Body Surface Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0481T	Injection(S), Autologous White Blood Cell Concentrate (Autologous Protein Solution), Any Site, Including Image Guidance, Harvesting And Preparation, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	1/1/2018	12/31/2999
0484T	Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic Valve; Transthoracic Exposure (Eg, Thoracotomy, Transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
0485T	Optical Coherence Tomography (Oct) Of Middle Ear, With Interpretation And Report; Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical Coherence Tomography (Oct) Of Middle Ear, With Interpretation And Report; Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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.	1/1/2018	12/31/2999
0495T	Initiation And Monitoring Marginal (Extended) Cadaver Donor Lung(S) Organ Perfusion System By Physician Or Qualified Health Care Professional, Including Physiological And Laboratory Assessment (Eg, Pulmonary Artery Flow, Pulmonary Artery Pressure, Left Atrial Pressure, Pulmonary Vascular Resistance, Mean/Peak And Plateau Airway Pressure, Dynamic Compliance And Perfusate Gas Analysis), Including Bronchoscopy And X Ray When Performed; First Two Hours In Sterile Field	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
0496T	Initiation And Monitoring Marginal (Extended) Cadaver Donor Lung(S) Organ Perfusion System By Physician Or Qualified Health Care Professional, Including Physiological And Laboratory Assessment (Eg, Pulmonary Artery Flow, Pulmonary Artery Pressure, Left Atrial Pressure, Pulmonary Vascular Resistance, Mean/Peak And Plateau Airway Pressure, Dynamic Compliance And Perfusate Gas Analysis), Including Bronchoscopy And X Ray When Performed; Each Additional Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
0507T	Near Infrared Dual Imaging (Ie, Simultaneous Reflective And Transilluminated Light) Of Meibomian Glands, Unilateral Or Bilateral, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2018	12/31/2999
0509T	Electroretinography (Erg) With Interpretation And Report, Pattern (Perg)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

0510T	Removal Of Sinus Tarsi Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0511T	Removal And Reinsertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0512T	Extracorporeal Shock Wave For Integumentary Wound Healing, Including Topical Application And Dressing Care; Initial Wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
0513T	Extracorporeal Shock Wave For Integumentary Wound Healing, Including Topical Application And Dressing Care; Each Additional Wound (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
0515T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming, And Imaging Supervision And Interpretation, When Performed; Complete System (Includes Electrode And Generator [Transmitter And Battery])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0516T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming, And Imaging Supervision And Interpretation, When Performed; Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0517T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming, And Imaging Supervision And Interpretation, When Performed; Both Components Of Pulse Generator (Battery And Transmitter) Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0518T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Battery Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0519T	Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming; Both Components (Battery And Transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0520T	Removal And Replacement 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.	9/1/2020	12/31/2999
0521T	Interrogation Device Evaluation (In Person) With Analysis, Review And Report, Includes Connection, Recording, And Disconnection Per Patient Encounter, Wireless Cardiac Stimulator For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0522T	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, Wireless Cardiac Stimulator For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
0525T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including Testing Of The Lead And Monitor, Initial System Programming, And Imaging Supervision And Interpretation; Complete System (Electrode And Implantable Monitor)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0526T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including Testing Of The Lead And Monitor, Initial System Programming, And Imaging Supervision And Interpretation; Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0527T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including Testing Of The Lead And Monitor, Initial System Programming, And Imaging Supervision And Interpretation; Implantable Monitor Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0528T	Programming Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring System With Iterative Adjustment Of Programmed Values, With Analysis, Review, And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0529T	Interrogation Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring System With Analysis, Review, And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0530T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging Supervision And Interpretation; Complete System (Electrode And Implantable Monitor)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0531T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging Supervision And Interpretation; Electrode Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0532T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging Supervision And Interpretation; Implantable Monitor Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	1/1/2019	12/31/2999
0538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Preparation Of Blood-Derived T Lymphocytes For Transportation (Eg, Cryopreservation, Storage)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
0539T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt And Preparation Of Car-T Cells For Administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
0540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Car-T Cell Administration, Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
0544T	Transcatheter Mitral Valve Annulus Reconstruction, With Implantation Of Adjustable Annulus Reconstruction Device, Percutaneous Approach Including Transseptal Puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0545T	Transcatheter Tricuspid Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device, Percutaneous Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
0546T	Radiofrequency Spectroscopy, Real Time, Intraoperative Margin Assessment, At The Time Of Partial Mastectomy, With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0552T	Low-Level Laser Therapy, Dynamic Photonic And Dynamic Thermokinetic Energies, Provided By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2019	12/31/2999
0563T	Evacuation Of Meibomian Glands, Using Heat Delivered Through Wearable, Open-Eye Eyelid Treatment Devices And Manual Gland Expression, Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

0565T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Tissue Harvesting And Cellular Implant Creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0566T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Injection Of Cellular Implant Into Knee Joint Including Ultrasound Guidance, Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
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.	8/15/2023	12/31/2999
0570T	Transcatheter Tricuspid Valve Repair, Percutaneous Approach; Each Additional Prosthesis During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
0581T	Ablation, Malignant Breast Tumor(S), Percutaneous, Cryotherapy, Including Imaging Guidance When Performed, Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0584T	Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion, Including All Imaging, Including Guidance, And Radiological Supervision And Interpretation, When Performed; Percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0585T	Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion, Including All Imaging, Including Guidance, And Radiological Supervision And Interpretation, When Performed; Laparoscopic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0586T	Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion, Including All Imaging, Including Guidance, And Radiological Supervision And Interpretation, When Performed; Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
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.	1/1/2020	12/31/2999
0588T	Revision Or Removal Of Percutaneously Placed Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator, Including Analysis, Programming, And Imaging Guidance When Performed, Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0589T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg, Electrode Array And Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed By Physician Or Other Qualified Health Care Professional, Posterior Tibial Nerve, 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
0590T	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg, Electrode Array And Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed By Physician Or Other Qualified Health Care Professional, Posterior Tibial Nerve, 4 Or More Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

0591T	Health And Well-Being Coaching Face-To-Face; Individual, Initial Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0592T	Health And Well-Being Coaching Face-To-Face; Individual, Follow-Up Session, At Least 30 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0593T	Health And Well-Being Coaching Face-To-Face; Group (2 Or More Individuals), At Least 30 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
0596T	Temporary Female Intraurethral Valve-Pump (Ie, Voiding Prosthesis); Initial Insertion, Including Urethral Measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0597T	Temporary Female Intraurethral Valve-Pump (Ie, Voiding Prosthesis); Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0598T	Noncontact Real-Time Fluorescence Wound Imaging, For Bacterial Presence, Location, And Load, Per Session; First Anatomic Site (Eg, Lower Extremity)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0599T	Noncontact Real-Time Fluorescence Wound Imaging, For Bacterial Presence, Location, And Load, Per Session; Each Additional Anatomic Site (Eg, Upper Extremity) (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
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.	7/1/2020	12/31/2999
0601T	Ablation, Irreversible Electroporation; 1 Or More Tumors Per Organ, Including Fluoroscopic And Ultrasound Guidance, When Performed, Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0602T	Glomerular Filtration Rate (Gfr) Measurement(S), Transdermal, Including Sensor Placement And Administration Of A Single Dose Of Fluorescent Pyrazine Agent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0603T	Glomerular Filtration Rate (Gfr) Monitoring, Transdermal, Including Sensor Placement And Administration Of More Than One Dose Of Fluorescent Pyrazine Agent, Each 24 Hours	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0604T	Optical Coherence Tomography (Oct) Of Retina, Remote, Patient-Initiated Image Capture And Transmission To A Remote Surveillance Center, Unilateral Or Bilateral; Initial Device Provision, Set-Up And Patient Education On Use Of Equipment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0605T	Optical Coherence Tomography (Oct) Of Retina, Remote, Patient-Initiated Image Capture And Transmission To A Remote Surveillance Center, Unilateral Or Bilateral; Remote Surveillance Center Technical Support, Data Analyses And Reports, With A Minimum Of 8 Daily Recordings, Each 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0606T	Optical Coherence Tomography (Oct) Of Retina, Remote, Patient-Initiated Image Capture And Transmission To A Remote Surveillance Center, Unilateral Or Bilateral; Review, Interpretation And Report By The Prescribing Physician Or Other Qualified Health Care Professional Of Remote Surveillance Center Data Analyses, Each 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999

0607T	Remote Monitoring Of An External Continuous Pulmonary Fluid Monitoring System, Including Measurement Of Radiofrequency-Derived Pulmonary Fluid Levels, Heart Rate, Respiration Rate, Activity, Posture, And Cardiovascular Rhythm (Eg, Ecg Data), Transmitted To A Remote 24-Hour Attended Surveillance Center; Set-Up And Patient Education On Use Of Equipment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0608T	Remote Monitoring Of An External Continuous Pulmonary Fluid Monitoring System, Including Measurement Of Radiofrequency-Derived Pulmonary Fluid Levels, Heart Rate, Respiration Rate, Activity, Posture, And Cardiovascular Rhythm (Eg, Ecg Data), Transmitted To A Remote 24-Hour Attended Surveillance Center; Analysis Of Data Received And Transmission Of Reports To The Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0613T	Percutaneous Transcatheter Implantation Of Interatrial Septal Shunt Device, Including Right And Left Heart Catheterization, Intracardiac Echocardiography, And Imaging Guidance By The Proceduralist, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0614T	Removal And Replacement Of Substernal Implantable Defibrillator Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0615T	Eye-Movement Analysis Without Spatial Calibration, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0616T	Insertion Of Iris Prosthesis, Including Suture Fixation And Repair Or Removal Of Iris, When Performed; Without Removal Of Crystalline Lens Or Intraocular Lens, Without Insertion Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0617T	Insertion Of Iris Prosthesis, Including Suture Fixation And Repair Or Removal Of Iris, When Performed; With Removal Of Crystalline Lens And Insertion Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0618T	Insertion Of Iris Prosthesis, Including Suture Fixation And Repair Or Removal Of Iris, When Performed; With Secondary Intraocular Lens Placement Or Intraocular Lens Exchange	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And Drug Delivery, Including Transrectal Ultrasound And Fluoroscopy, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0620T	Endovascular Venous Arterialization, Tibial Or Peroneal Vein, With Transcatheter Placement Of Intravascular Stent Graft(S) And Closure By Any Method, Including Percutaneous Or Open Vascular Access, Ultrasound Guidance For Vascular Access When Performed, All Catheterization(S) And Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention, All Associated Radiological Supervision And Interpretation, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0621T	Trabeculostomy Ab Interno By Laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0622T	Trabeculostomy Ab Interno By Laser; With Use Of Ophthalmic Endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999

0623T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary Computed Tomographic Angiography; Data Preparation And Transmission, Computerized Analysis Of Data, With Review Of Computerized Analysis Output To Reconcile Discordant Data, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0624T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary Computed Tomographic Angiography; Data Preparation And Transmission	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0625T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary Computed Tomographic Angiography; Computerized Analysis Of Data From Coronary Computed Tomographic Angiography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0626T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary Computed Tomographic Angiography; Review Of Computerized Analysis Output To Reconcile Discordant Data, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0627T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product, Intervertebral Disc, Unilateral Or Bilateral Injection, With Fluoroscopic Guidance, Lumbar; First Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0628T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product, Intervertebral Disc, Unilateral Or Bilateral Injection, With Fluoroscopic Guidance, Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0629T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product, Intervertebral Disc, Unilateral Or Bilateral Injection, With Ct Guidance, Lumbar; First Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0630T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product, Intervertebral Disc, Unilateral Or Bilateral Injection, With Ct Guidance, Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0631T	Transcutaneous Visible Light Hyperspectral Imaging Measurement Of Oxyhemoglobin, Deoxyhemoglobin, And Tissue Oxygenation, With Interpretation And Report, Per Extremity	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0632T	Percutaneous Transcatheter Ultrasound Ablation Of Nerves Innervating The Pulmonary Arteries, Including Right Heart Catheterization, Pulmonary Artery Angiography, And All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0639T	Wireless Skin Sensor Thermal Anisotropy Measurement(S) And Assessment Of Flow In Cerebrospinal Fluid Shunt, Including Ultrasound Guidance, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0640T	Noncontact Near-Infrared Spectroscopy (Eg, For Measurement Of Deoxyhemoglobin, Oxyhemoglobin, And Ratio Of Tissue Oxygenation), Other Than For Screening For Peripheral Arterial Disease, Image Acquisition, Interpretation, And Report; First Anatomic Site	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0643T	Transcatheter Left Ventricular Restoration Device Implantation Including Right And Left Heart Catheterization And Left Ventriculography When Performed, Arterial Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999

0645T	Transcatheter Implantation Of Coronary Sinus Reduction Device Including Vascular Access And Closure, Right Heart Catheterization, Venous Angiography, Coronary Sinus Angiography, Imaging Guidance, And Supervision And Interpretation, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0646T	Transcatheter Tricuspid Valve Implantation (Ttvi)/Replacement With Prosthetic Valve, Percutaneous Approach, Including Right Heart Catheterization, Temporary Pacemaker Insertion, And Selective Right Ventricular Or Right Atrial Angiography, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0650T	Programming Device Evaluation (Remote) Of Subcutaneous Cardiac Rhythm Monitor System, With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanently Programmed Values With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0651T	Magnetically Controlled Capsule Endoscopy, Esophagus Through Stomach, Including Intraprocedural Positioning Of Capsule, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0655T	Transperineal Focal Laser Ablation Of Malignant Prostate Tissue, Including Transrectal Imaging Guidance, With Mr-Fused Images Or Other Enhanced Ultrasound Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0656T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0657T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
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.	7/1/2021	12/31/2999
0659T	Transcatheter Intracoronary Infusion Of Supersaturated Oxygen In Conjunction With Percutaneous Coronary Revascularization During Acute Myocardial Infarction, Including Catheter Placement, Imaging Guidance (Eg, Fluoroscopy), Angiography, And Radiologic Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0664T	Donor Hysterectomy (Including Cold Preservation); Open, From Cadaver Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0665T	Donor Hysterectomy (Including Cold Preservation); Open, From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0666T	Donor Hysterectomy (Including Cold Preservation); Laparoscopic Or Robotic, From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0667T	Donor Hysterectomy (Including Cold Preservation); Recipient Uterus Allograft Transplantation From Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0668T	Backbench Standard Preparation Of Cadaver Or Living Donor Uterine Allograft Prior To Transplantation, Including Dissection And Removal Of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(Ies), As Necessary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

0669T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0670T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0671T	Insertion Of Anterior Segment Aqueous Drainage Device Into The Trabecular Meshwork, Without External Reservoir, And Without Concomitant Cataract Removal, One Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0672T	Endovaginal Cryogen-Cooled, Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0673T	Ablation, Benign Thyroid Nodule(S), Percutaneous, Laser, Including Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0686T	Histotripsy (Ie, Non-Thermal Ablation Via Acoustic Energy Delivery) Of Malignant Hepatocellular Tissue, Including Image Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0687T	Treatment Of Amblyopia Using An Online Digital Program; Device Supply, Educational Set-Up, And Initial Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0688T	Treatment Of Amblyopia Using An Online Digital Program; Assessment Of Patient Performance And Program Data By Physician Or Other Qualified Health Care Professional, With Report, Per Calendar Month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0692T	Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0693T	Comprehensive Full Body Computer-Based Markerless 3D Kinematic And Kinetic Motion Analysis And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0700T	Molecular Fluorescent Imaging Of Suspicious Nevus; First Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0701T	Molecular Fluorescent Imaging Of Suspicious Nevus; 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.	1/1/2022	12/31/2999
0707T	Injection(S), Bone-Substitute Material (Eg, Calcium Phosphate) Into Subchondral Bone Defect (Ie, Bone Marrow Lesion, Bone Bruise, Stress Injury, Microtrabecular Fracture), Including Imaging Guidance And Arthroscopic Assistance For Joint Visualization	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0710T	Noninvasive Arterial Plaque Analysis Using Software Processing Of Data From Non-Coronary Computerized Tomography Angiography; Including Data Preparation And Transmission, Quantification Of The Structure And Composition Of The Vessel Wall And Assessment For Lipid-Rich Necrotic Core Plaque To Assess Atherosclerotic Plaque Stability, Data Review, Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0711T	Noninvasive Arterial Plaque Analysis Using Software Processing Of Data From Non-Coronary Computerized Tomography Angiography; Data Preparation And Transmission	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999

0712T	Noninvasive Arterial Plaque Analysis Using Software Processing Of Data From Non-Coronary Computerized Tomography Angiography; Quantification Of The Structure And Composition Of The Vessel Wall And Assessment For Lipid-Rich Necrotic Core Plaque To Assess Atherosclerotic Plaque Stability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0713T	Noninvasive Arterial Plaque Analysis Using Software Processing Of Data From Non-Coronary Computerized Tomography Angiography; Data Review, Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
0714T	Transperineal Laser Ablation Of Benign Prostatic Hyperplasia, Including Imaging Guidance; Prostate Volume Less Than 50 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0719T	Posterior Vertebral Joint Replacement, Including Bilateral Facetectomy, Laminectomy, And Radical Discectomy, Including Imaging Guidance, Lumbar Spine, Single Segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0720T	Percutaneous Electrical Nerve Field Stimulation, Cranial Nerves, Without Implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0733T	Remote Real-Time, Motion Capture-Based Neurorehabilitative Therapy Ordered By A Physician Or Other Qualified Health Care Professional; Supply And Technical Support, Per 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0734T	Remote Real-Time, Motion Capture-Based Neurorehabilitative Therapy Ordered By A Physician Or Other Qualified Health Care Professional; Treatment Management Services By A Physician Or Other Qualified Health Care Professional, Per Calendar Month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0737T	Xenograft Implantation Into The Articular Surface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0740T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set-Up And Patient Education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0741T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software, Data Collection, Transmission, And Storage, Each 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0743T	Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd), With Concurrent Vertebral Fracture Assessment, Utilizing Data From A Computed Tomography Scan, Retrieval And Transmission Of The Scan Data, Measurement Of Bone Strength And Bmd And Classification Of Any Vertebral Fractures, With Overall Fracture-Risk Assessment, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0744T	Insertion Of Bioprosthetic Valve, Open, Femoral Vein, Including Duplex Ultrasound Imaging Guidance, When Performed, Including Autogenous Or Nonautogenous Patch Graft (Eg, Polyester, Eptfe, Bovine Pericardium), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0745T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Noninvasive Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus), Derived From Anatomical Image Data (Eg, Ct, Mri, Or Myocardial Perfusion Scan) And Electrical Data (Eg, 12-Lead Ecg Data), And Identification Of Areas Of Avoidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999

0746T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Conversion Of Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Into A Multidimensional Radiation Treatment Plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0747T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Delivery Of Radiation Therapy, Arrhythmia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0748T	Injections Of Stem Cell Product Into Perianal Perifistular Soft Tissue, Including Fistula Preparation (Eg, Removal Of Setons, Fistula Curettage, Closure Of Internal Openings)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0764T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg, Low-Ejection Fraction, Pulmonary Hypertension, Hypertrophic Cardiomyopathy); Related To Concurrently Performed Electrocardiogram (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg, Low-Ejection Fraction, Pulmonary Hypertension, Hypertrophic Cardiomyopathy); Related To Previously Performed Electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0766T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse, Peripheral Nerve, With Identification And Marking Of The Treatment Location, Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization), When Performed; First Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0767T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse, Peripheral Nerve, With Identification And Marking Of The Treatment Location, Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization), When Performed; Each Additional Nerve (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0770T	Virtual Reality Technology To Assist Therapy (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0771T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports, Requiring The Presence Of An Independent, Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Initial 15 Minutes Of Intraservice Time, Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports, Requiring The Presence Of An Independent, Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0773T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Initial 15 Minutes Of Intraservice Time, Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0774T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0776T	Therapeutic Induction Of Intra-Brain Hypothermia, Including Placement Of A Mechanical Temperature-Controlled Cooling Device To The Neck Over Carotids And Head, Including Monitoring (Eg, Vital Signs And Sport Concussion Assessment Tool 5 [Scat5]), 30 Minutes Of Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0777T	Real-Time Pressure-Sensing Epidural Guidance System (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0778T	Surface Mechanomyography (Smmg) With Concurrent Application Of Inertial Measurement Unit (Imu) Sensors For Measurement Of Multi-Joint Range Of Motion, Posture, Gait, And Muscle Function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0779T	Gastrointestinal Myoelectrical Activity Study, Stomach Through Colon, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0780T	Instillation Of Fecal Microbiota Suspension Via Rectal Enema Into Lower Gastrointestinal Tract	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
0781T	Bronchoscopy, Rigid Or Flexible, With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves, Including Fluoroscopic Guidance When Performed; Bilateral Mainstem Bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0782T	Bronchoscopy, Rigid Or Flexible, With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves, Including Fluoroscopic Guidance When Performed; Unilateral Mainstem Bronchus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0783T	Transcutaneous Auricular Neurostimulation, Set-Up, Calibration, And Patient Education On Use Of Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
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.	1/1/2024	12/31/2999
0785T	Revision Or Removal Of Neurostimulator Electrode Array, Spinal, With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0786T	Insertion Or Replacement Of Percutaneous Electrode Array, Sacral, With Integrated Neurostimulator, Including Imaging Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

0787T	Revision Or Removal Of Neurostimulator Electrode Array, Sacral, With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0788T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System (Eg, Electrode Array And Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed By Physician Or Other Qualified Health Care Professional, Spinal Cord Or Sacral Nerve, 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0789T	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System (Eg, Electrode Array And Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed By Physician Or Other Qualified Health Care Professional, Spinal Cord Or Sacral Nerve, 4 Or More Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0790T	Revision (Eg, Augmentation, Division Of Tether), Replacement, Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering, Including Thoracoscopy, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0791T	Motor-Cognitive, Semi-Immersive Virtual Reality-Facilitated Gait Training, Each 15 Minutes (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0792T	Application Of Silver Diamine Fluoride 38%, By A Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	12/31/2999
0793T	Percutaneous Transcatheter Thermal Ablation Of Nerves Innervating The Pulmonary Arteries, Including Right Heart Catheterization, Pulmonary Artery Angiography, And All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0794T	Patient-Specific, Assistive, Rules-Based Algorithm For Ranking Pharmaco-Oncologic Treatment Options Based On The Patient'S Tumor-Specific Cancer Marker Information Obtained From Prior Molecular Pathology, Immunohistochemical, Or Other Pathology Results Which Have Been Previously Interpreted And Reported Separately	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0795T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Complete System (Ie, Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0796T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Right Atrial Pacemaker Component (When An Existing Right Ventricular Single Leadless Pacemaker Exists To Create A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0797T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0798T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography), When Performed; Complete System (Ie, Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0799T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography), When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0800T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography), When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0801T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Dual-Chamber System (Ie, Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0802T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0803T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography, Right Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0804T	Programming Device Evaluation (In Person) With Iterative Adjustment Of Implantable Device To Test The Function Of Device And To Select Optimal Permanent Programmed Values, With Analysis, Review, And Report, By A Physician Or Other Qualified Health Care Professional, Leadless Pacemaker System In Dual Cardiac Chambers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie, Caval Valve Implantation [Cavi]); Percutaneous Femoral Vein Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

0806T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie, Caval Valve Implantation [Cavi]); Open Femoral Vein Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0807T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Previously Acquired Computed Tomography (Ct) Images, Including Data Preparation And Transmission, Quantification Of Pulmonary Tissue Ventilation, Data Review, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0808T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Computed Tomography (Ct) Images Taken For The Purpose Of Pulmonary Tissue Ventilation Analysis, Including Data Preparation And Transmission, Quantification Of Pulmonary Tissue Ventilation, Data Review, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0810T	Subretinal Injection Of A Pharmacologic Agent, Including Vitrectomy And 1 Or More Retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0813T	Esophagogastroduodenoscopy, Flexible, Transoral, With Volume Adjustment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0814T	Percutaneous Injection Of Calcium-Based Biodegradable Osteoconductive Material, Proximal Femur, Including Imaging Guidance, Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg, Array Or Leadless), And Pulse Generator Or Receiver, Including Analysis, Programming, And Imaging Guidance, When Performed, Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0817T	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; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction, Including Analysis, Programming, And Imaging, When Performed, Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0819T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction, Including Analysis, Programming, And Imaging, When Performed, Posterior Tibial Nerve; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0820T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis Intervention), As Needed, During Psychedelic Medication Therapy; First Physician Or Other Qualified Health Care Professional, Each Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0821T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis Intervention), As Needed, During Psychedelic Medication Therapy; Second Physician Or Other Qualified Health Care Professional, Concurrent With First Physician Or Other Qualified Health Care Professional, Each 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.	1/1/2024	12/31/2999

0822T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis Intervention), As Needed, During Psychedelic Medication Therapy; Clinical Staff Under The Direction Of A Physician Or Other Qualified Health Care Professional, Concurrent With First Physician Or Other Qualified Health Care Professional, Each 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.	1/1/2024	12/31/2999
0823T	Transcatheter Insertion Of Permanent Single-Chamber Leadless Pacemaker, Right Atrial, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography And/Or Right Ventriculography, Femoral Venography, Cavography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0824T	Transcatheter Removal Of Permanent Single-Chamber Leadless Pacemaker, Right Atrial, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography And/Or Right Ventriculography, Femoral Venography, Cavography), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0825T	Transcatheter Removal And Replacement Of Permanent Single-Chamber Leadless Pacemaker, Right Atrial, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial Angiography And/Or Right Ventriculography, Femoral Venography, Cavography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0826T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional, Leadless Pacemaker System In Single-Cardiac Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0857T	Opto-Acoustic Imaging, Breast, Unilateral, Including Axilla When Performed, Real-Time With Image Documentation, Augmentative Analysis And Report (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0858T	Externally Applied Transcranial Magnetic Stimulation With Concomitant Measurement Of Evoked Cortical Potentials With Automated Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
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.	1/1/2024	12/31/2999
0862T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming; Battery Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0863T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing, Including Device Interrogation And Programming; Transmitter Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum, Low Energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

0865T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With Comparison To Prior Magnetic Resonance (Mr) Study(Ies), Including Lesion Identification, Characterization, And Quantification, With Brain Volume(S) Quantification And/Or Severity Score, When Performed, Data Preparation And Transmission, Interpretation And Report, Obtained Without Diagnostic Mri Examination Of The Brain During The Same Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0866T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With Comparison To Prior Magnetic Resonance (Mr) Study(Ies), Including Lesion Detection, Characterization, And Quantification, With Brain Volume(S) Quantification And/Or Severity Score, When Performed, Data Preparation And Transmission, Interpretation And Report, Obtained With Diagnostic Mri Examination Of The Brain (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0867T	Transperineal Laser Ablation Of Benign Prostatic Hyperplasia, Including Imaging Guidance; Prostate Volume Greater Or Equal To 50 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0868T	High-Resolution Gastric Electrophysiology Mapping With Simultaneous Patientsymptom Profiling, With Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0870T	Implantation Of Subcutaneous Peritoneal Ascites Pump System, Percutaneous, Including Pump-Pocket Creation, Insertion Of Tunneled Indwelling Bladder And Peritoneal Catheters With Pump Connections, Including All Imaging And Initial Programming, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0871T	Replacement Of A Subcutaneous Peritoneal Ascites Pump, Including Reconnection Between Pump And Indwelling Bladder And Peritoneal Catheters, Including Initial Programming And Imaging, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0872T	Replacement Of Indwelling Bladder And Peritoneal Catheters, Including Tunneling Of Catheter(S) And Connection With Previously Implanted Peritoneal Ascites Pump, Including Imaging And Programming, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0873T	Revision Of A Subcutaneously Implanted Peritoneal Ascites Pump System, Any Component (Ascites Pump, Associated Peritoneal Catheter, Associated Bladder Catheter), Including Imaging And Programming, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0874T	Removal Of A Peritoneal Ascites Pump System, Including Implanted Peritoneal Ascites Pump And Indwelling Bladder And Peritoneal Catheters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0875T	Programming Of Subcutaneously Implanted Peritoneal Ascites Pump System By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0876T	Duplex Scan Of Hemodialysis Fistula, Computer-Aided, Limited (Volume Flow, Diameter, And Depth, Including Only Body Of Fistula)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0882T	Intraoperative Therapeutic Electrical Stimulation Of Peripheral Nerve To Promote Nerve Regeneration, Including Lead Placement And Removal, Upper Extremity, Minimum Of 10 Minutes; Initial Nerve (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.	7/1/2024	12/31/2999

0883T	Intraoperative Therapeutic Electrical Stimulation Of Peripheral Nerve To Promote Nerve Regeneration, Including Lead Placement And Removal, Upper Extremity, Minimum Of 10 Minutes; Each Additional Nerve (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.	7/1/2024	12/31/2999
0884T	Esophagoscopy, Flexible, Transoral, With Initial Transendoscopic Mechanical Dilation (Eg, Nondrug-Coated Balloon) Followed By Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Esophageal Stricture, Including Fluoroscopic Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0885T	Colonoscopy, Flexible, With Initial Transendoscopic Mechanical Dilation (Eg, Nondrug-Coated Balloon) Followed By Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Colonic Stricture, Including Fluoroscopic Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0886T	Sigmoidoscopy, Flexible, With Initial Transendoscopic Mechanical Dilation (Eg, Nondrug-Coated Balloon) Followed By Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Colonic Stricture, Including Fluoroscopic Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0888T	Histotripsy (Ie, Non-Thermal Ablation Via Acoustic Energy Delivery) Of Malignant Renal Tissue, Including Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0889T	Personalized Target Development For Accelerated, Repetitive High-Dose Functional Connectivity Mri-Guided Theta-Burst Stimulation Derived From A Structural And Resting-State Functional Mri, Including Data Preparation And Transmission, Generation Of The Target, Motor Threshold-Starting Location, Neuronavigation Files And Target Report, Review And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0890T	Accelerated, Repetitive High-Dose Functional Connectivity Mri-Guided Theta-Burst Stimulation, Including Target Assessment, Initial Motor Threshold Determination, Neuronavigation, Delivery And Management, Initial Treatment Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0891T	Accelerated, Repetitive High-Dose Functional Connectivity Mri-Guided Theta-Burst Stimulation, Including Neuronavigation, Delivery And Management, Subsequent Treatment Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
0892T	Accelerated, Repetitive High-Dose Functional Connectivity Mri-Guided Theta-Burst Stimulation, Including Neuronavigation, Delivery And Management, Subsequent Motor Threshold Redetermination With Delivery And Management, Per Treatment Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
3051F	Most Recent Hemoglobin A1C (Hba1C) Level Greater Than Or Equal To 7.0% And Less Than 8.0% (Dm)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
3052F	Most Recent Hemoglobin A1C (Hba1C) Level Greater Than Or Equal To 8.0% And Less Than Or Equal To 9.0% (Dm)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
9001F	Aortic Aneurysm Less Than 5.0 Cm Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
9002F	Aortic Aneurysm 5.0 - 5.4 Cm Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
9003F	Aortic Aneurysm 5.5 - 5.9 Cm Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

9004F	Aortic Aneurysm 6.0 Cm Or Greater Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
9005F	Asymptomatic Carotid Stenosis: No History Of Any Transient Ischemic Attack Or Stroke In Any Carotid Or Vertebrobasilar Territory (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
9006F	Symptomatic Carotid Stenosis: Ipsilateral Carotid Territory Tia Or Stroke Less Than 120 Days Prior To Procedure (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
9007F	Other Carotid Stenosis: Ipsilateral Tia Or Stroke 120 Days Or Greater Prior To Procedure Or Any Prior Contralateral Carotid Territory Or Vertebrobasilar Tia Or Stroke (Nma-No Measure Associated)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
A0021	Ambulance Service, Outside State Per Mile, Transport (Medicaid Only)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0080	Non-Emergency Transportation, Per Mile - Vehicle Provided By Volunteer (Individual Or Organization), With No Vested Interest	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0090	Non-Emergency Transportation, Per Mile - Vehicle Provided By Individual (Family Member, Self, Neighbor) With Vested Interest	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0100	Non-Emergency Transportation; Taxi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0110	Non-Emergency Transportation And Bus, Intra Or Inter State Carrier	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0120	Non-Emergency Transportation: Mini-Bus, Mountain Area Transports, Or Other Transportation Systems	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0130	Non-Emergency Transportation: Wheel-Chair Van	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0140	Non-Emergency Transportation And Air Travel (Private Or Commercial) Intra Or Inter State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0160	Non-Emergency Transportation: Per Mile - Case Worker Or Social Worker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0170	Transportation Ancillary: Parking Fees, Tolls, Other	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0180	Non-Emergency Transportation: Ancillary: Lodging-Recipient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0190	Non-Emergency Transportation: Ancillary: Meals-Recipient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0200	Non-Emergency Transportation: Ancillary: Lodging Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0210	Non-Emergency Transportation: Ancillary: Meals-Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0225	Ambulance Service, Neonatal Transport, Base Rate, Emergency Transport, One Way	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0380	Bls Mileage (Per Mile)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0390	Als Mileage (Per Mile)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999

A0420	Ambulance Waiting Time (Als Or Bls), One Half (1/2) Hour Increments	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0424	Extra Ambulance Attendant, Ground (Als Or Bls) Or Air (Fixed Or Rotary Winged); (Requires Medical Review)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0425	Ground Mileage, Per Statute Mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0426	Ambulance Service, Advanced Life Support, Non-Emergency Transport, Level 1 (Als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
A0427	Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 (Als1-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
A0428	Ambulance Service, Basic Life Support, Non-Emergency Transport, (Bls)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2015	12/31/2999
A0429	Ambulance Service, Basic Life Support, Emergency Transport (Bls-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0432	Paramedic Intercept (Pi), Rural Area, Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing Third Party Payers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A0433	Advanced Life Support, Level 2 (Als 2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A0434	Specialty Care Transport (Sct)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
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.	9/1/2020	12/31/2999
A0998	Ambulance Response And Treatment, No Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A0999	Unlisted Ambulance Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
A2001	Innovamatrix Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2002	Mirragen Advanced Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2004	Xcellistem, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2005	Microlyte Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999

A2006	Novosorb Synpath Dermal Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2007	Restrata, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2008	Theragenesis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2009	Symphony, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2010	Apis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
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).	4/1/2022	12/31/2999
A2012	Suprathel, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A2013	Innovamatrix Fs, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
A2014	Omeza Collagen Matrix, Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2015	Phoenix Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2016	Permeaderm B, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2017	Permeaderm Glove, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2018	Permeaderm C, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2019	Kerecis Omega3 Marigen Shield, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2020	Ac5 Advanced Wound System (Ac5)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2021	Neomatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

A2022	Innovaburn Or Innovamatrix Xl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2023	Innovamatrix Pd, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2024	Resolve Matrix Or Xenopatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2025	Miro3D, Per Cubic Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2026	Restrata Minimatrix, 5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
A4100	Skin Substitute, Fda Cleared As A Device, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
A4226	Supplies For Maintenance Of Insulin Infusion Pump With Dosage Rate Adjustment Using Therapeutic Continuous Glucose Sensing, Per Week	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
A4244	Alcohol Or Peroxide, Per Pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4245	Alcohol Wipes, Per Box	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4246	Betadine Or Phisohex Solution, Per Pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4247	Betadine Or Iodine Swabs/Wipes, Per Box	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4290	Sacral Nerve Stimulation Test Lead, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A4337	Incontinence Supply, Rectal Insert, Any Type, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
A4341	Indwelling Intraurethral Drainage Device With Valve, Patient Inserted, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4342	Accessories For Patient Inserted Indwelling Intraurethral Drainage Device With Valve, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4438	Adhesive Clip Applied To The Skin To Secure External Electrical Nerve Stimulator Controller, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
A4450	Tape, Non-Waterproof, Per 18 Square Inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4452	Tape, Waterproof, Per 18 Square Inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4453	Rectal Catheter For Use With The Manual Pump-Operated Enema System, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999

A4457	Enema Tube, With Or Without Adapter, Any Type, Replacement Only, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
A4458	Enema Bag With Tubing, Reusable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	8/1/2019	12/31/2999
A4459	Manual Pump-Operated Enema System, Includes Balloon, Catheter And All Accessories, Reusable, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
A4468	Exsufflation Belt, Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
A4490	Surgical Stockings Above Knee Length, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4495	Surgical Stockings Thigh Length, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4500	Surgical Stockings Below Knee Length, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4510	Surgical Stockings Full Length, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4520	Incontinence Garment, Any Type, (E.G. Brief, Diaper), Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
A4540	Distal Transcutaneous Electrical Nerve Stimulator, Stimulates Peripheral Nerves Of The Upper Arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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.	1/1/2024	12/31/2999
A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4553	Non-Disposable Underpads, All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
A4554	Disposable Underpads, All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
A4555	Electrode/Transducer For Use With Electrical Stimulation Device Used For Cancer Treatment, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
A4556	Electrodes, (E. G. , Apnea Monitor), Per Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A4557	Lead Wires, (E. G. , Apnea Monitor), Per Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A4560	Neuromuscular Electrical Stimulator (Nmes), Disposable, Replacement Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

A4595	Electrical Stimulator Supplies, 2 Lead, Per Month, (E. G. Tens, Nmes)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A4596	Cranial Electrotherapy Stimulation (Ces) System Supplies And Accessories, Per Month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A4600	Sleeve For Intermittent Limb Compression Device, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A4606	Oxygen Probe For Use With Oximeter Device, Replacement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/15/2022	12/31/2999
A4630	Replacement Batteries, Medically Necessary, Transcutaneous Electrical Stimulator, Owned By Patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
A4639	Replacement Pad For Infrared Heating Pad System, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
A4660	Sphygmomanometer/Blood Pressure Apparatus With Cuff And Stethoscope	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4663	Blood Pressure Cuff Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4870	Plumbing And/Or Electrical Work For Home Hemodialysis Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4927	Gloves, Non-Sterile, Per 100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4928	Surgical Mask, Per 20	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4930	Gloves, Sterile, Per Pair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4931	Oral Thermometer, Reusable, Any Type, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A4932	Rectal Thermometer, Reusable, Any Type, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A6000	Non-Contact Wound Warming Wound Cover For Use With The Non-Contact Wound Warming Device And Warming Card	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
A6550	Wound Care Set, For Negative Pressure Wound Therapy Electrical Pump, Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A7020	Interface For Cough Stimulating Device, Includes All Components, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A7025	High Frequency Chest Wall Oscillation System Vest, Replacement For Use With Patient Owned Equipment, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

A7026	High Frequency Chest Wall Oscillation System Hose, Replacement For Use With Patient Owned Equipment, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A7049	Expiratory Positive Airway Pressure Intranasal Resistance Valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A8000	Helmet, Protective, Soft, Prefabricated, Includes All Components And Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A8001	Helmet, Protective, Hard, Prefabricated, Includes All Components And Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A8002	Helmet, Protective, Soft, Custom Fabricated, Includes All Components And Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A8003	Helmet, Protective, Hard, Custom Fabricated, Includes All Components And Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A8004	Soft Interface For Helmet, Replacement Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A9150	Non-Prescription Drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2012	12/31/2999
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2012	12/31/2999
A9272	Wound Suction, Disposable, Includes Dressing, All Accessories And Components, Any Type, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
A9273	Cold Or Hot Fluid Bottle, Ice Cap Or Collar, Heat And/Or Cold Wrap, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A9281	Reaching/Grabbing Device, Any Type, Any Length, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
A9282	Wig, Any Type, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2015	12/31/2999
A9285	Inversion/Eversion Correction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
A9286	Hygienic Item Or Device, Disposable Or Non-Disposable, Any Type, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy, Fda Cleared, Per Course Of Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
A9515	Choline C-11, Diagnostic, Per Study Dose Up To 20 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2018	12/31/2999
A9526	Nitrogen N-13 Ammonia, Diagnostic, Per Study Dose, Up To 40 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
A9552	Fluorodeoxyglucose F-18 Fdg, Diagnostic, Per Study Dose, Up To 45 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

A9555	Rubidium Rb-82, Diagnostic, Per Study Dose, Up To 60 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
A9573	Injection, Gadopiclenol, 1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
A9580	Sodium Fluoride F-18, Diagnostic, Per Study Dose, Up To 30 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
A9582	Iodine I-123 Iobenguane, Diagnostic, Per Study Dose, Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
A9586	Florbetapir F18, Diagnostic, Per Study Dose, Up To 10 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
A9587	Gallium Ga-68, Dotatate, Diagnostic, 0.1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
A9588	Fluciclovine F-18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
A9591	Fluoroestradiol F 18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
A9592	Copper Cu-64, Dotatate, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
A9593	Gallium Ga-68 Psma-11, Diagnostic, (Ucsf), 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
A9594	Gallium Ga-68 Psma-11, Diagnostic, (Ucla), 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
A9595	Piflufolastat F-18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
A9596	Gallium Ga-68 Gozetotide, Diagnostic, (Illuccix), 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
A9597	Positron Emission Tomography Radiopharmaceutical, Diagnostic, For Tumor Identification, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
A9598	Positron Emission Tomography Radiopharmaceutical, Diagnostic, For Non-Tumor Identification, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
A9601	Flortaucipir F 18 Injection, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

A9602	Fluorodopa F-18, Diagnostic, Per Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
A9608	Flotufolastat F 18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
A9609	Fludeoxyglucose F18 Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
A9800	Gallium Ga-68 Gozetotide, Diagnostic, (Locametz), 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
B4100	Food Thickener, Administered Orally, Per Ounce	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
B4102	Enteral Formula, For Adults, Used To Replace Fluids And Electrolytes (E.G. Clear Liquids), 500 Ml = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2020	12/31/2999
B4103	Enteral Formula, For Pediatrics, Used To Replace Fluids And Electrolytes (E.G. Clear Liquids), 500 Ml = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2020	12/31/2999
B4104	Additive For Enteral Formula (E.G. Fiber)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2020	12/31/2999
B4105	In-Line Cartridge Containing Digestive Enzyme(S) For Enteral Feeding, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2020	12/31/2999
B4149	Enteral Formula, Manufactured Blenderized Natural Foods With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4150	Enteral Formula, Nutritionally Complete With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4152	Enteral Formula, Nutritionally Complete, Calorically Dense (Equal To Or Greater Than 1. 5 Kcal/Ml) With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4153	Enteral Formula, Nutritionally Complete, Hydrolyzed Proteins (Amino Acids And Peptide Chain), Includes Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4154	Enteral Formula, Nutritionally Complete, For Special Metabolic Needs, Excludes Inherited Disease Of Metabolism, Includes Altered Composition Of Proteins, Fats, Carbohydrates, Vitamins And/Or Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

B4155	Enteral Formula, Nutritionally Incomplete/Modular Nutrients, Includes Specific Nutrients, Carbohydrates (E. G. Glucose Polymers), Proteins/Amino Acids (E. G. Glutamine, Arginine), Fat (E. G. Medium Chain Triglycerides) Or Combination, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4158	Enteral Formula, For Pediatrics, Nutritionally Complete With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber And/Or Iron, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4159	Enteral Formula, For Pediatrics, Nutritionally Complete Soy Based With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber And/Or Iron, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4160	Enteral Formula, For Pediatrics, Nutritionally Complete Calorically Dense (Equal To Or Greater Than 0.7 Kcal/Ml) With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4161	Enteral Formula, For Pediatrics, Hydrolyzed/Amino Acids And Peptide Chain Proteins, Includes Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4164	Parenteral Nutrition Solution: Carbohydrates (Dextrose), 50% Or Less (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4168	Parenteral Nutrition Solution; Amino Acid, 3. 5%, (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4172	Parenteral Nutrition Solution; Amino Acid, 5. 5% Through 7%, (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4176	Parenteral Nutrition Solution; Amino Acid, 7% Through 8. 5%, (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4178	Parenteral Nutrition Solution: Amino Acid, Greater Than 8. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose), Greater Than 50% (500 Ml=1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4185	Parenteral Nutrition Solution, Not Otherwise Specified, 10 Grams Lipids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4187	Omegaven, 10 Grams Lipids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
B4189	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength, 10 To 51 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

B4193	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength, 52 To 73 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4197	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements And Vitamins, Including Preparation, Any Strength, 74 To 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4199	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements And Vitamins, Including Preparation, Any Strength, Over 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4216	Parenteral Nutrition; Additives (Vitamins, Trace Elements, Heparin, Electrolytes) Homemix Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4220	Parenteral Nutrition Supply Kit; Premix, Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4222	Parenteral Nutrition Supply Kit; Home Mix, Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B4224	Parenteral Nutrition Administration Kit, Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B5000	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength, Renal-Aminosyn-Rf, Nephramine, Renamine-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B5100	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength, Hepatic, Hepatamine-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B5200	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength, Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B9002	Enteral Nutrition Infusion Pump, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B9004	Parenteral Nutrition Infusion Pump, Portable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
B9006	Parenteral Nutrition Infusion Pump, Stationary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C1052	Hemostatic Agent, Gastrointestinal, Topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C1062	Intravertebral Body Fracture Augmentation With Implant (E.G., Metal, Polymer)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999

C1600	Catheter, Transluminal Intravascular Lesion Preparation Device, Bladed, Sheathed (Insertable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
C1605	Pacemaker, Leadless, Dual Chamber (Right Atrial And Right Ventricular Implantable Components), Rate-Responsive, Including All Necessary Components For Implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
C1717	Brachytherapy Source High Dose Rate "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C1721	Aicd, Dual Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1722	Aicd, Single Chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1734	Orthopedic/Device/Drug Matrix For Opposing Bone-To-Bone Or Soft Tissue-To Bone (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
C1761	Catheter, Transluminal Intravascular Lithotripsy, Coronary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
C1764	Event Recorder, Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2018	12/31/2999
C1767	Generator, Neurostimulator (Implantable), Non-Rechargeable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
C1778	Lead, Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
C1783	Ocular Implant, Aqueous Drainage Assist Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1787	Patient Progr, Neurostim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
C1816	Receiver/Transmitter, Neuro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
C1817	Septal Defect Imp Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

C1820	Generator, Neurostimulator (Implantable), With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
C1821	Interspinous Process Distraction Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
C1823	Generator, Neurostimulator (Implantable), Non-Rechargeable, With Transvenous Sensing And Stimulation Leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
C1824	Generator, Cardiac Contractility Modulation (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
C1825	Generator, Neurostimulator (Implantable), Non-Rechargeable With Carotid Sinus Baroreceptor Stimulation Lead(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
C1826	Generator, Neurostimulator (Implantable), Includes Closed Feedback Loop Leads And All Implantable Components, With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
C1827	Generator, Neurostimulator (Implantable), Non-Rechargeable, With Implantable Stimulation Lead And External Paired Stimulation Controller	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
C1831	Interbody Cage, Anterior, Lateral Or Posterior, Personalized (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
C1832	Autograft Suspension, Including Cell Processing And Application, And All System Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
C1833	Monitor, Cardiac, Including Intracardiac Lead And All System Components (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C1840	Lens, Intraocular (Telescopic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/27/2013	12/31/2999
C1882	Aicd, Other Than Sing/Dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1883	Adapt/Ext, Pacing/Neuro Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
C1895	Lead, Aicd, Endo Dual Coil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1896	Lead, Aicd, Non Sing/Dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1897	Lead, Neurostim Test Kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999

C1899	Lead, Pmkr/Aicd Combination	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
C1982	Catheter, Pressure-Generating, One-Way Valve, Intermittently Occlusive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
C2614	Probe, Percutaneous Lumbar Discectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
C2616	Brachytx Source, Yttrium-90 "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	12/15/2016	12/31/2999
C2624	Implantable Wireless Pulmonary Artery Pressure Sensor With Delivery Catheter, Including All System Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
C2634	Brachytherapy Source, High Activity, Iodine-125, Per Source "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2635	Brachytherapy Source, High Activity, Paladium-103, Per Source "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2636	Brachytherapy Linear Source, Paladium-103, Per 1 Mm "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2637	Brachytherapy Source, Ytterbium-169, Per Source "Non-Stranded"	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2638	Brachytherapy Source, Stranded, Iodine-125, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2639	Brachytherapy Source, Non-Stranded, Iodine-125, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2640	Brachytherapy Source, Stranded, Palladium-103, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2641	Brachytherapy Source, Non-Stranded, Palladium-103, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2642	Brachytherapy Source, Stranded, Cesium-131, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C2643	Brachytherapy Source, Non-Stranded, Cesium-131, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

C2644	Brachytherapy Source, Cesium-131 Chloride Solution, Per Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
C2645	Brachytherapy Planar Source, Palladium-103, Per Square Millimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
C2698	Brachytherapy Source, Stranded, Not Otherwise Specified, Per Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C5271	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5272	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5273	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area, Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5274	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5275	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5276	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5277	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area, Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5278	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C7504	Percutaneous Vertebroplasties (Bone Biopsies Included When Performed), First Cervicothoracic And Any Additional Cervicothoracic Or Lumbosacral Vertebral Bodies, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

C7505	Percutaneous Vertebroplasties (Bone Biopsies Included When Performed), First Lumbosacral And Any Additional Cervicothoracic Or Lumbosacral Vertebral Bodies, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
C7507	Percutaneous Vertebral Augmentations, First Thoracic And Any Additional Thoracic Or Lumbar Vertebral Bodies, Including Cavity Creations (Fracture Reductions And Bone Biopsies Included When Performed) Using Mechanical Device (Eg, Kyphoplasty), Unilateral Or Bilateral Cannulations, Inclusive Of All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
C7508	Percutaneous Vertebral Augmentations, First Lumbar And Any Additional Thoracic Or Lumbar Vertebral Bodies, Including Cavity Creations (Fracture Reductions And Bone Biopsies Included When Performed) Using Mechanical Device (Eg, Kyphoplasty), Unilateral Or Bilateral Cannulations, Inclusive Of All Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
C9047	Injection, Caplacizumab-Yhdp, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2019	12/31/2999
C9067	Gallium Ga-68, Dotatoc, Diagnostic, 0.01 Mci	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
C9354	Acellular Pericardial Tissue Matrix Of Non-Human Origin (Veritas), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9356	Tendon, Porous Matrix Of Cross-Linked Collagen And Glycosaminoglycan Matrix (Tenoglide Tendon Protector Sheet), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9358	Dermal Substitute, Native, Non-Denatured Collagen, Fetal Bovine Origin (Surgimend Collagen Matrix), Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9359	Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra Os Osteoconductive Scaffold Putty), Per 0.5 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
C9360	Dermal Substitute, Native, Non-Denatured Collagen, Neonatal Bovine Origin (Surgimend Collagen Matrix), Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9362	Porous Purified Collagen Matrix Bone Void Filler (Integra Mozaik Osteoconductive Scaffold Strip), Per 0.5 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
C9363	Skin Substitute, Integra Meshed Bilayer Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C9364	Porcine Implant, Permacol, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9726	Placement And Removal (If Performed) Of Applicator Into Breast For Radiation Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
C9727	Insertion Of Implants Into The Soft Palate; Minimum Of Three Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

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.	7/1/2015	12/31/2999
C9739	Cystourethroscopy, With Insertion Of Transprostatic Implant; 1 To 3 Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9740	Cystourethroscopy, With Insertion Of Transprostatic Implant; 4 Or More Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9751	Bronchoscopy, Rigid Or Flexible, Transbronchial Ablation Of Lesion(S) By Microwave Energy, Including Fluoroscopic Guidance, When Performed, With Computed Tomography Acquisition(S) And 3-D Rendering, Computer-Assisted, Image-Guided Navigation, And Endobronchial Ultrasound (Ebus) Guided Transtracheal And/Or Transbronchial Sampling (Eg, Aspiration[S]/Biopsy[Ies]) And All Mediastinal And/Or Hilar Lymph Node Stations Or Structures And Therapeutic Intervention(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
C9757	Laminotomy (Hemilaminectomy), With Decompression Of Nerve Root(S), Including Partial Facetectomy, Foraminotomy And Excision Of Herniated Intervertebral Disc, And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Closure Device, Including Annular Defect Measurement, Alignment And Sizing Assessment, And Image Guidance; 1 Interspace, Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9760	Non-Randomized, Non-Blinded Procedure For Nyha Class Ii, Iii, Iv Heart Failure; Transcatheter Implantation Of Interatrial Shunt, Including Right And Left Heart Catheterization, Transeptal Puncture, Trans-Esophageal Echocardiography (Tee)/Intracardiac Echocardiography (Ice), And All Imaging With Or Without Guidance (E.G., Ultrasound, Fluoroscopy), Performed In An Approved Investigational Device Exemption (Ide) Study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2020	12/31/2999
C9762	Cardiac Magnetic Resonance Imaging For Morphology And Function, Quantification Of Segmental Dysfunction; With Strain Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2021	12/31/2999
C9764	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9765	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, And Transluminal Stent Placement(S), Includes Angioplastyš Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9766	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy And Atherectomy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9767	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S), And Atherectomy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9768	Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999

C9769	Cystourethroscopy, With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
C9772	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal Artery(Ies), With Intravascular Lithotripsy, Includes Angioplasty Within The Same Vessel (S), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9773	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy, And Transluminal Stent Placement(S), Includes Angioplasty Within The Same Vessel(S), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9774	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Atherectomy, Includes Angioplasty Within The Same Vessel (S), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9775	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Transluminal Stent Placement(S), And Atherectomy, Includes Angioplasty Within The Same Vessel (S), When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9777	Esophageal Mucosal Integrity Testing By Electrical Impedance, Transoral, Includes Esophagoscopy Or Esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9778	Colpopexy, Vaginal; Minimally Invasive Extra-Peritoneal Approach (Sacrospinous)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2022	12/31/2999
C9783	Blinded Procedure For Transcatheter Implantation Of Coronary Sinus Reduction Device Or Placebo Control, Including Vascular Access And Closure, Right Heart Catherization, Venous And Coronary Sinus Angiography, Imaging Guidance And Supervision And Interpretation When Performed In An Approved Investigational Device Exemption (Ide) Study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2022	12/31/2999
C9784	Gastric Restrictive Procedure, Endoscopic Sleeve Gastroplasty, With Esophagogastroduodenoscopy And Intraluminal Tube Insertion, If Performed, Including All System And Tissue Anchoring Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9785	Endoscopic Outlet Reduction, Gastric Pouch Application, With Endoscopy And Intraluminal Tube Insertion, If Performed, Including All System And Tissue Anchoring Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9786	Echocardiography Image Post Processing For Computer Aided Detection Of Heart Failure With Preserved Ejection Fraction, Including Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999

C9792	Blinded Or Nonblinded Procedure For Symptomatic New York Heart Association (Nyha) Class Ii, Iii, Iva Heart Failure; Transcatheter Implantation Of Left Atrial To Coronary Sinus Shunt Using Jugular Vein Access, Including All Imaging Necessary To Intra Procedurally Map The Coronary Sinus For Optimal Shunt Placement (E.G., Tee Or Ice Ultrasound, Fluoroscopy), Performed Under General Anesthesia In An Approved Investigational Device Exemption (Ide) Study)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2023	12/31/2999
C9793	3D Predictive Model Generation For Pre-Planning Of A Cardiac Procedure, Using Data From Cardiac Computed Tomographic Angiography With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
C9794	Therapeutic Radiology Simulation-Aided Field Setting; Complex, Including Acquisition Of Pet And Ct Imaging Data Required For Radiopharmaceutical-Directed Radiation Therapy Treatment Planning (I.E., Modeling)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
C9795	Stereotactic Body Radiation Therapy, Treatment Delivery, Per Fraction To 1 Or More Lesions, Including Image Guidance And Real-Time Positron Emissions-Based Delivery Adjustments To 1 Or More Lesions, Entire Course Not To Exceed 5 Fractions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G., Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
D0120	Periodic Oral Evaluation - Established Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0140	Limited Oral Evaluation - Problem Focused	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0145	Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0150	Comprehensive Oral Evaluation - New Or Established Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0171	Re-Evaluation ? Post-Operative Office Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0190	Screening Of A Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0191	Assessment Of A Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0210	Intraoral - Comprehensive Series Of Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0220	Intraoral - Periapical First Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0230	Intraoral - Periapical Each Additional Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0240	Intraoral - Occlusal Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D0250	Extraoral - First Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0270	Bitewing - Single Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0272	Bitewings - Two Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0273	Bitewings - Three Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0274	Bitewings - Four Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0310	Sialography	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0320	Temporomandibular Joint Arthrogram, Including Injection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0321	Other Temporomandibular Joint Radiographic Images, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0322	Tomographic Survey	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0330	Panoramic Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0340	Cephalometric Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0350	2D Oral/Facial Photographic Image Obtained Intra-Orally Or Extra-Orally	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0364	Cone Beam Ct Capture And Interpretation With Limited Field Of View ? Less Than One Whole Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0365	Cone Beam Ct Capture And Interpretation With Field Of View Of One Full Dental Arch ? Mandible	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0366	Cone Beam Ct Capture And Interpretation With Field Of View Of One Full Dental Arch ? Maxilla, With Or Without Cranium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0367	Cone Beam Ct Capture And Interpretation With Field Of View Of Both Jaws, With Or Without Cranium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0368	Cone Beam Ct Capture And Interpretation For Tmj Series Including Two Or More Exposures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0369	Maxillofacial Mri Capture And Interpretation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0370	Maxillofacial Ultrasound Capture And Interpretation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0372	Intraoral Tomosynthesis ? Comprehensive Series Of Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0373	Intraoral Tomosynthesis ? Bitewing Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0374	Intraoral Tomosynthesis ? Periapical Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0380	Cone Beam Ct Image Capture With Limited Field Of View ? Less Than One Whole Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0381	Cone Beam Ct Image Capture With Field Of View Of One Full Dental Arch ? Mandible	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D0382	Cone Beam Ct Image Capture With Field Of View Of One Full Dental Arch ? Maxilla, With Or Without Cranium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0383	Cone Beam Ct Image Capture With Field Of View Of Both Jaws, With Or Without Cranium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0384	Cone Beam Ct Image Capture For Tmj Series Including Two Or More Exposures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0385	Maxillofacial Mri Image Capture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0386	Maxillofacial Ultrasound Image Capture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0387	Intraoral Tomosynthesis ? Comprehensive Series Of Radiographic Images - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0388	Intraoral Tomosynthesis ? Bitewing Radiographic Image - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0389	Intraoral Tomosynthesis ? Periapical Radiographic Image - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0393	Virtual Treatment Simulation Using 3D Image Volume Or Surface Scan	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0394	Digital Subtraction Of Two Or More Images Or Image Volumes Of The Same Modality	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0395	Fusion Of Two Or More 3D Image Volumes Of One Or More Modalities	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0396	3D Printing Of A 3D Dental Surface Scan	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
D0415	Collection Of Microorganisms For Culture And Sensitivity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0416	Viral Culture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0417	Collection And Preparation Of Saliva Sample For Laboratory Diagnostic Testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0418	Analysis Of Saliva Sample	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0419	Assessment Of Salivary Flow By Measurement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D0422	Collection And Preparation Of Genetic Sample Material For Laboratory Analysis And Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D0423	Genetic Test For Susceptibility To Diseases ? Specimen Analysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D0425	Caries Susceptibility Tests	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0431	Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions, Not To Include Cytology Or Biopsy Procedures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0460	Pulp Vitality Tests	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0470	Diagnostic Casts	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0472	Accession Of Tissue, Gross Examination, Preparation And Transmission Of Written Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D0473	Accession Of Tissue, Gross And Microscopic Examination, Preparation And Transmission Of Written Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0474	Accession Of Tissue, Gross And Microscopic Examination, Including Assessment Of Surgical Margins For Presence Of Disease, Preparation And Transmission Of Written Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0480	Accession Of Exfoliative Cytologic Smears, Microscopic Examination, Preparation And Transmission Of Written Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D0600	Non-Ionizing Diagnostic Procedure Capable Of Quantifying, Monitoring, And Recording Changes In Structure Of Enamel, Dentin And Cementum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D0701	Panoramic Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0702	2-D Cephalometric Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0703	2D Oral/Facial Photographic Image Obtained Intra-Orally Or Extra-Orally ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0705	Extra-Oral Posterior Dental Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0706	Intraoral ? Occlusal Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0707	Intraoral ? Periapical Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0708	Intraoral ? Bitewing Radiographic Image ? Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0709	Intraoral - Comprehensive Series Of Radiographic Images - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D0801	3D Dental Surface Scan ? Direct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0802	3D Dental Surface Scan ? Indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0803	3D Facial Surface Scan ? Direct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D0804	3D Facial Surface Scan ? Indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D1110	Prophylaxis - Adult	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1120	Prophylaxis - Child	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1206	Topical Application Of Fluoride Varnish	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1208	Topical Application Of Fluoride ? Excluding Varnish	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1301	Immunization Counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

D1310	Nutritional Counseling For Control Of Dental Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1330	Oral Hygiene Instructions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1351	Sealant - Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1352	Preventive Resin Restoration In A Moderate To High Caries Risk Patient ? Permanent Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1353	Sealant Repair ? Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D1354	Application Of Caries Arresting Medicament ? Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D1355	Caries Preventive Medicament Application ? Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D1510	Space Maintainer ? Fixed Unilateral ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1520	Space Maintainer ? Removable ? Unilateral ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D1526	Space Maintainer ? Removable ? Bilateral, Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D1527	Space Maintainer ? Removable ? Bilateral, Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1556	Removal Of Fixed Unilateral Space Maintainer ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1557	Removal Of Fixed Bilateral Space Maintainer ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1558	Removal Of Fixed Bilateral Space Maintainer ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D1575	Distal Shoe Space Maintainer ? Fixed ? Unilateral ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D1999	Unspecified Preventive Procedure, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D2140	Amalgam - One Surface, Primary Or Permanent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2150	Amalgam - Two Surfaces, Primary Or Permanent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2160	Amalgam - Three Surfaces, Primary Or Permanent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2330	Resin-Based Composite - One Surface, Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D2331	Resin-Based Composite - Two Surfaces, Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2332	Resin-Based Composite - Three Surfaces, Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2335	Resin-Based Composite - Four Or More Surfaces (Anterior)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2390	Resin-Based Composite Crown, Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2391	Resin-Based Composite - One Surface, Posterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2392	Resin-Based Composite - Two Surfaces, Posterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2393	Resin-Based Composite - Three Surfaces, Posterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2410	Gold Foil - One Surface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2420	Gold Foil - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2430	Gold Foil - Three Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2510	Inlay - Metallic - One Surface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2520	Inlay - Metallic - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2530	Inlay - Metallic - Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2542	Onlay - Metallic-Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2543	Onlay - Metallic-Three Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2544	Onlay - Metallic-Four Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2610	Inlay - Porcelain/Ceramic - One Surface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2650	Inlay - Resin-Based Composite - One Surface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2651	Inlay - Resin-Based Composite - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2662	Onlay - Resin-Based Composite - Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2663	Onlay - Resin-Based Composite - Three Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2710	Crown - Resin-Based Composite (Indirect)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2712	Crown - ¾ Resin-Based Composite (Indirect)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2720	Crown - Resin With High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2721	Crown - Resin With Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2722	Crown - Resin With Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2740	Crown - Porcelain/Ceramic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2750	Crown - Porcelain Fused To High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2752	Crown - Porcelain Fused To Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D2780	Crown - 3/4 Cast High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2781	Crown - 3/4 Cast Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2782	Crown - 3/4 Cast Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2783	Crown - 3/4 Porcelain/Ceramic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2790	Crown - Full Cast High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2791	Crown - Full Cast Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2792	Crown - Full Cast Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2794	Crown ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2799	Interim Crown ? Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2915	Re-Cement Or Re-Bond Indirectly Fabricated Or Prefabricated Post And Core	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D2920	Re-Cement Or Re-Bond Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D2928	Prefabricated Porcelain/Ceramic Crown ? Permanent Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D2929	Prefabricated Porcelain/Ceramic Crown ? Primary Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2932	Prefabricated Resin Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2933	Prefabricated Stainless Steel Crown With Resin Window	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2940	Protective Restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2941	Interim Therapeutic Restoration ? Primary Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D2949	Restorative Foundation For An Indirect Restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D2950	Core Buildup, Including Any Pins When Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2951	Pin Retention - Per Tooth, In Addition To Restoration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2954	Prefabricated Post And Core In Addition To Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2955	Post Removal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2957	Each Additional Prefabricated Post - Same Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2960	Labial Veneer (Resin Laminate) - Chairside	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2961	Labial Veneer (Resin Laminate) - Laboratory	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2975	Coping	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2980	Crown Repair Necessitated By Restorative Material Failure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D2989	Excavation Of A Tooth Resulting In The Determination Of Non-Restorability	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

D2991	Application Of Hydroxyapatite Regeneration Medicament - Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
D3110	Pulp Cap - Direct (Excluding Final Restoration)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal Of Pulp Coronal To The Dentinocemental Junction And Application Of Medicament To Be Performed On Primary Or Permanent Teeth. This Is Not To Be Construed As The First Stage Of Root Canal Therapy. Not To Be Used For Apexogenesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3221	Pulpal Debridement, Primary And Permanent Teeth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restorations)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restorations)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3331	Treatment Of Root Canal Obstruction; Non-Surgical Access	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3333	Internal Root Repair Of Perforation Defects	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3347	Retreatment Of Previous Root Canal Therapy ? Premolar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3348	Retreatment Of Previous Root Canal Therapy - Molar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3351	Apexification/Recalcification ? Initial Visit (Apical Closure / Calcific Repair Of Perforations, Root Resorption, Etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulp Space Disinfection, Etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3355	Pulpal Regeneration - Initial Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3356	Pulpal Regeneration - Interim Medication Replacement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

D3357	Pulpal Regeneration - Completion Of Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3421	Apicoectomy ? Premolar (First Root)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3425	Apicoectomy - Molar (First Root)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3426	Apicoectomy (Each Additional Root)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3428	Bone Graft In Conjunction With Periradicular Surgery ? Per Tooth, Single Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3429	Bone Graft In Conjunction With Periradicular Surgery ? Each Additional Contiguous Tooth In The Same Surgical Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3430	Retrograde Filling - Per Root	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3431	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration In Conjunction With Periradicular Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3432	Guided Tissue Regeneration, Resorbable Barrier, Per Site, In Conjunction With Periradicular Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D3450	Root Amputation - Per Root	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3460	Endodontic Endosseous Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3470	Intentional Reimplantation (Including Necessary Splinting)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3471	Surgical Repair Of Root Resorption ? Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3472	Surgical Repair Of Root Resorption ? Premolar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3473	Surgical Repair Of Root Resorption ? Molar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3501	Surgical Exposure Of Root Surface Without Apicoectomy Or Repair Of Root Resorption ? Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3502	Surgical Exposure Of Root Surface Without Apicoectomy Or Repair Of Root Resorption ? Premolar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3503	Surgical Exposure Of Root Surface Without Apicoectomy Or Repair Of Root Resorption ? Molar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D3910	Surgical Procedure For Isolation Of Tooth With Rubber Dam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3911	Intraorifice Barrier	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D3921	Decoronation Or Submergence Of An Erupted Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4230	Anatomical Crown Exposure ? Four Or More Contiguous Teeth Or Tooth Bounded Tooth Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4231	Anatomical Crown Exposure ? One To Three Teeth Or Tooth Bounded Tooth Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4245	Apically Positioned Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4249	Clinical Crown Lengthening ? Hard Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) ? Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) ? One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4265	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration, Per Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4266	Guided Tissue Regeneration, Natural Teeth - Resorbable Barrier, Per Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4267	Guided Tissue Regeneration, Natural Teeth - Non-Resorbable Barrier, Per Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4268	Surgical Revision Procedure, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4270	Pedicle Soft Tissue Graft Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4275	Soft Tissue Allograft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4276	Combined Connective Tissue And Pedicle Graft, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), First Tooth Or Edentulous Tooth Position In Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), Each Additional Contiguous Tooth Or Edentulous Tooth Position In Same Graft Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) ? Each Additional Contiguous Tooth, Implant Or Edentulous Tooth Position In Same Graft Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D4285	Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) ? Each Additional Contiguous Tooth, Implant Or Edentulous Tooth Position In Same Graft Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D4322	Splint ? Intra-Coronal; Natural Teeth Or Prosthetic Crowns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D4323	Splint ? Extra-Coronal; Natural Teeth Or Prosthetic Crowns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation ? Full Mouth, After Oral Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D4355	Full Mouth Debridement To Enable A Comprehensive Periodontal Evaluation And Diagnosis On A Subsequent Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4910	Periodontal Maintenance	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Their Staff)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D4921	Gingival Irrigation With A Medicinal Agent - Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D5110	Complete Denture - Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5120	Complete Denture - Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5130	Immediate Denture - Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5140	Immediate Denture - Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5211	Maxillary Partial Denture ? Resin Base (Including Any Conventional Clasps Retentive/Clasping Materials, Rests, And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5212	Mandibular Partial Denture ? Resin Base (Including Any Conventional Clasps Retentive/Clasping Materials, Rests, And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5221	Immediate Maxillary Partial Denture ? Resin Base (Including Retentive/Clasping Materials, Rests And Teeth) Rebasing/Relining Procedure(S).	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D5222	Immediate Mandibular Partial Denture ? Resin Base (Including Retentive/Clasping Materials, Rests And Teeth) Rebasing/Relining Procedure(S).	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

D5223	Immediate Maxillary Partial Denture ? Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D5224	Immediate Mandibular Partial Denture ? Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5227	Immediate Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D5228	Immediate Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D5282	Removable Unilateral Partial Denture ? One Piece Cast Metal (Including Clasps And Teeth), Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D5283	Removable Unilateral Partial Denture ? One Piece Cast Metal (Including Clasps And Teeth), Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D5284	Removable Unilateral Partial Denture ? One Piece Flexible Base (Including Clasps And Teeth) ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D5286	Removable Unilateral Partial Denture ? One Piece Resin (Including Clasps And Teeth) ? Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D5410	Adjust Complete Denture - Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5411	Adjust Complete Denture - Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5421	Adjust Partial Denture - Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5422	Adjust Partial Denture - Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5630	Repair Or Replace Broken Clasp Retentive/Clasping Materials Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5640	Replace Broken Teeth - Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5650	Add Tooth To Existing Partial Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5660	Add Clasp To Existing Partial Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5710	Rebase Complete Maxillary Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5711	Rebase Complete Mandibular Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5720	Rebase Maxillary Partial Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D5721	Rebase Mandibular Partial Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5725	Rebase Hybrid Prosthesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D5730	Reline Complete Maxillary Denture (Chairside)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5731	Reline Complete Mandibular Denture (Chairside)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5740	Reline Maxillary Partial Denture (Chairside)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5741	Reline Mandibular Partial Denture (Chairside)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5750	Reline Complete Maxillary Denture (Laboratory)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5751	Reline Complete Mandibular Denture (Laboratory)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5760	Reline Maxillary Partial Denture (Laboratory)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5761	Reline Mandibular Partial Denture (Laboratory)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5765	Soft Liner For Complete Or Partial Removable Denture ? Indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D5810	Interim Complete Denture (Maxillary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5811	Interim Complete Denture (Mandibular)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5820	Interim Partial Denture (Maxillary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5821	Interim Partial Denture (Mandibular)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5850	Tissue Conditioning, Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5851	Tissue Conditioning, Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5862	Precision Attachment, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5863	Overdenture ? Complete Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D5864	Overdenture ? Partial Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D5865	Overdenture ? Complete Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D5866	Overdenture ? Partial Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D5867	Replacement Of Replaceable Part Of Semi-Precision Or Precision Attachment, Per Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5875	Modification Of Removable Prosthesis Following Implant Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5876	Add Metal Substructure To Acrylic Full Denture (Per Arch)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

D5937	Trismus Appliance (Not For Tmd Treatment)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5982	Surgical Stent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5986	Fluoride Gel Carrier	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5988	Surgical Splint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5991	Vesiculobullous Disease Medicament Carrier	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D5995	Periodontal Medicament Carrier With Peripheral Seal ? Laboratory Processed, Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D5996	Periodontal Medicament Carrier With Peripheral Seal ? Laboratory Processed, Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D6010	Surgical Placement Of Implant Body: Endosteal Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6011	Second Stage Implant Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D6012	Surgical Placement Of Interim Implant Body For Transitional Prosthesis: Endosteal Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6013	Surgical Placement Of Mini Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D6040	Surgical Placement: Eposteal Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6050	Surgical Placement: Transosteal Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6055	Connecting Bar ? Implant Supported Or Abutment Supported	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6056	Prefabricated Abutment ? Includes Modification And Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6057	Custom Fabricated Abutment ? Includes Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6058	Abutment Supported Porcelain/Ceramic Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6065	Implant Supported Porcelain/Ceramic Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6066	Implant Supported Crown ? Porcelain Fused To High Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D6067	Implant Supported Crown ? High Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Predominantly Base Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6073	Abutment Supported Retainer For Cast Metal Fpd (Predominantly Base Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6075	Implant Supported Retainer For Ceramic Fpd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6076	Implant Supported Retainer For Fpd ? Porcelain Fused To High Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6077	Implant Supported Retainer For Metal Fpd ? High Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6080	Implant Maintenance Procedures When Prostheses Are Removed And Reinserted, Including Cleansing Of Prostheses And Abutments	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6081	Scaling And Debridement In The Presence Of Inflammation Or Mucositis Of A Single Implant, Including Cleaning Of The Implant Surfaces, Without Flap Entry And Closure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D6082	Implant Supported Crown ? Porcelain Fused To Predominantly Base Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6083	Implant Supported Crown ? Porcelain Fused To Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6084	Implant Supported Crown ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6085	Interim Implant Crown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D6086	Implant Supported Crown ? Predominantly Base Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6087	Implant Supported Crown ? Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6088	Implant Supported Crown ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6091	Replacement Of Replaceable Part Of Semi-Precision Or Precision Attachment Of Implant/Abutment Supported Prosthesis, Per Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6094	Abutment Supported Crown ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6097	Abutment Supported Crown ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6098	Implant Supported Retainer ? Porcelain Fused To Predominantly Base Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

D6099	Implant Supported Retainer For Fpd ? Porcelain Fused To Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6105	Removal Of Implant Body Not Requiring Bone Removal Nor Flap Elevation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D6110	Implant /Abutment Supported Removable Denture For Edentulous Arch ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6111	Implant /Abutment Supported Removable Denture For Edentulous Arch ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6112	Implant /Abutment Supported Removable Denture For Partially Edentulous Arch ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6113	Implant /Abutment Supported Removable Denture For Partially Edentulous Arch ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6114	Implant /Abutment Supported Fixed Denture For Edentulous Arch ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6115	Implant /Abutment Supported Fixed Denture For Edentulous Arch ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6116	Implant /Abutment Supported Fixed Denture For Partially Edentulous Arch ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6117	Implant /Abutment Supported Fixed Denture For Partially Edentulous Arch ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6120	Implant Supported Retainer ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6121	Implant Supported Retainer For Metal Fpd ? Predominantly Base Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6122	Implant Supported Retainer For Metal Fpd ? Noble Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6123	Implant Supported Retainer For Metal Fpd ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6191	Semi-Precision Abutment - Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D6192	Semi-Precision Attachment - Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
D6194	Abutment Supported Retainer Crown For Fpd ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6195	Abutment Supported Retainer ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6197	Replacement Of Restorative Material Used To Close An Access Opening Of A Screw-Retained Implant Supported Prosthesis, Per Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
D6198	Remove Interim Implant Component	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D6205	Pontic - Indirect Resin Based Composite	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6210	Pontic - Cast High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6211	Pontic - Cast Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6212	Pontic - Cast Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D6214	Pontic ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6240	Pontic - Porcelain Fused To High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6242	Pontic - Porcelain Fused To Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6243	Pontic ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6245	Pontic - Porcelain/Ceramic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6250	Pontic - Resin With High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6251	Pontic - Resin With Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6252	Pontic - Resin With Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6253	Interim Pontic ? Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6549	Resin Retainer ? For Resin Bonded Fixed Prosthesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D6600	Inlay - Porcelain/Ceramic, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6601	Inlay - Porcelain/Ceramic, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6602	Inlay - Cast High Noble Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6603	Inlay - Cast High Noble Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6605	Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6606	Inlay - Cast Noble Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6607	Inlay - Cast Noble Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6608	Onlay -Porcelain/Ceramic, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6609	Onlay - Porcelain/Ceramic, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6610	Onlay - Cast High Noble Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6611	Onlay - Cast High Noble Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6613	Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6614	Onlay - Cast Noble Metal, Two Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6615	Onlay - Cast Noble Metal, Three Or More Surfaces	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6624	Inlay - Titanium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6634	Onlay - Titanium	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6710	Crown - Indirect Resin Based Composite	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6720	Crown - Resin With High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6721	Crown - Resin With Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6722	Crown - Resin With Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6740	Crown - Porcelain/Ceramic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6750	Crown - Porcelain Fused To High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6751	Crown - Porcelain Fused To Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6752	Crown - Porcelain Fused To Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6753	Retainer Crown ? Porcelain Fused To Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6780	Crown - 3/4 Cast High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6781	Crown - 3/4 Cast Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6782	Crown - 3/4 Cast Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6783	Crown - 3/4 Porcelain/Ceramic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6784	Retainer Crown ¾ ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D6790	Crown - Full Cast High Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6791	Crown - Full Cast Predominantly Base Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6792	Crown - Full Cast Noble Metal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6794	Retainer Crown ? Titanium And Titanium Alloys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6920	Connector Bar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D6930	Re-Cement Or Re-Bond Fixed Partial Denture	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6940	Stress Breaker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6950	Precision Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D6985	Pediatric Partial Denture, Fixed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7111	Extraction, Coronal Remnants ? Primary Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7251	Coronectomy - Intentional Partial Tooth Removal, Impacted Teeth Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7272	Tooth Transplantation (Includes Reimplantation From One Site To Another And Splinting And/Or Stabilization)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7280	Exposure Of An Unerupted Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7287	Exfoliative Cytological Sample Collection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7288	Brush Biopsy - Transepithelial Sample Collection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7290	Surgical Repositioning Of Teeth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7292	Placement Of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7293	Placement Of Temporary Anchorage Device Requiring Flap;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7294	Placement Of Temporary Anchorage Device Without Flap;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7310	Alveoloplasty In Conjunction With Extractions Four Or More Teeth Or Tooth Spaces, Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7320	Alveoloplasty Not In Conjunction With Extractions Four Or More Teeth Or Tooth Spaces, Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7350	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Muscle Reattachment, Revision Of Soft Tissue Attachment And Management Of Hypertrophied And Hyperplastic Tissue)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7472	Removal Of Torus Palatinus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7473	Removal Of Torus Mandibularis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7810	Open Reduction Of Dislocation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7820	Closed Reduction Of Dislocation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7830	Manipulation Under Anesthesia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7840	Condylectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7850	Surgical Discectomy, With/Without Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7852	Disc Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7854	Synovectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7856	Myotomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7858	Joint Reconstruction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7860	Arthrotomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7865	Arthroplasty	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7870	Arthrocentesis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7871	Non-Arthroscopic Lysis And Lavage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D7873	Arthroscopy: Lavage And Lysis Of Adhesions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7874	Arthroscopy: Disc Repositioning And Stabilization	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7875	Arthroscopy: Synovectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7876	Arthroscopy: Discectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7877	Arthroscopy: Debridement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7880	Occlusal Orthotic Device, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7881	Occlusal Orthotic Device Adjustment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D7921	Collection And Application Of Autologous Blood Concentrate Product	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7939	Indexing For Osteotomy Using Dynamic Robotic Assisted Or Dynamic Navigation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla - Autogenous Or Nonautogenous, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7953	Bone Replacement Graft For Ridge Preservation - Per Site	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7970	Excision Of Hyperplastic Tissue - Per Arch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D7971	Excision Of Pericoronal Gingiva	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8010	Limited Orthodontic Treatment Of The Primary Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8040	Limited Orthodontic Treatment Of The Adult Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8210	Removable Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

D8670	Periodic Orthodontic Treatment Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D8681	Removable Orthodontic Retainer Adjustment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D8696	Repair Of Orthodontic Appliance ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8697	Repair Of Orthodontic Appliance ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8698	Re-Cement Or Re-Bond Fixed Retainer ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8699	Re-Cement Or Re-Bond Fixed Retainer ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8701	Repair Of Fixed Retainer, Includes Reattachment ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8702	Repair Of Fixed Retainer, Includes Reattachment ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8703	Replacement Of Lost Or Broken Retainer ? Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D8704	Replacement Of Lost Or Broken Retainer ? Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D9110	Palliative Treatment Of Dental Pain - Per Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9120	Fixed Partial Denture Sectioning	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9130	Temporomandibular Joint Dysfunction ? Non-Invasive Physical Therapies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
D9210	Local Anesthesia Not In Conjunction With Operative Or Surgical Procedures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9211	Regional Block Anesthesia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9212	Trigeminal Division Block Anesthesia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9215	Local Anesthesia In Conjunction With Operative Or Surgical Procedures	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9219	Evaluation For Moderate Sedation, Deep Sedation Or General Anesthesia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D9230	Inhalation Of Nitrous Oxide / Anxiolysis, Analgesia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9243	Intravenous Moderate (Conscious) Sedation/Anesthesia ? Each Subsequent 15 Minute Increment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9248	Non-Intravenous Moderate (Conscious) Sedation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9311	Consultation With A Medical Health Care Professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

D9410	House/Extended Care Facility Call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9420	Hospital Or Ambulatory Surgical Center Call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9440	Office Visit - After Regularly Scheduled Hours	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9450	Case Presentation, Subsequent To Detailed And Extensive Treatment Planning	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9610	Therapeutic Parenteral Drug, Single Administration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations, Different Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9613	Infiltration Of Sustained Release Therapeutic Drug, Per Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D9630	Drugs Or Medicaments Dispensed In The Office For Home Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9910	Application Of Desensitizing Medicament	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9911	Application Of Desensitizing Resin For Cervical And/Or Root Surface, Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9912	Pre-Visit Patient Screening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
D9920	Behavior Management, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9932	Cleaning And Inspection Of Removable Complete Denture, Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9933	Cleaning And Inspection Of Removable Complete Denture, Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9934	Cleaning And Inspection Of Removable Partial Denture, Maxillary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9935	Cleaning And Inspection Of Removable Partial Denture, Mandibular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9938	Fabrication Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
D9939	Placement Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
D9941	Fabrication Of Athletic Mouthguard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9942	Repair And/Or Reline Of Occlusal Guard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9943	Occlusal Guard Adjustment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
D9944	Occlusal Guard ? Hard Appliance, Full Arch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D9945	Occlusal Guard ? Soft Appliance, Full Arch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D9946	Occlusal Guard ? Hard Appliance, Partial Arch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

D9947	Custom Sleep Apnea Appliance Fabrication And Placement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
D9948	Adjustment Of Custom Sleep Apnea Appliance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
D9949	Repair Of Custom Sleep Apnea Appliance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
D9950	Occlusion Analysis - Mounted Case	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9951	Occlusal Adjustment - Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9952	Occlusal Adjustment - Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9954	Fabrication And Delivery Of Oral Appliance Therapy (Oat) Morning Repositioning Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
D9955	Oral Appliance Therapy (Oat) Titration Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
D9956	Administration Of Home Sleep Apnea Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
D9957	Screening For Sleep Related Breathing Disorders	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
D9961	Duplicate/Copy Patient'S Records	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
D9970	Enamel Microabrasion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9971	Odontoplasty 1 - 2 Teeth; Includes Removal Of Enamel Projections	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9972	External Bleaching ? Per Arch ? Performed In Office	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9973	External Bleaching - Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9974	Internal Bleaching - Per Tooth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9975	External Bleaching For Home Application, Per Arch; Includes Materials And Fabrication Of Custom Trays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
D9985	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
D9986	Missed Appointment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D9987	Cancelled Appointment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
D9990	Certified Translation Or Sign-Language Services Per Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

D9991	Dental Case Management - Addressing Appointment Compliance Barriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D9992	Dental Case Management ? Care Coordination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D9993	Dental Case Management - Motivational Interviewing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
D9995	Teledentistry - Synchronous; Real-Time Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist For Subsequent Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
D9997	Dental Case Management ? Patients With Special Health Care Needs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
D9999	Unspecified Adjunctive Procedure, By Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2013	12/31/2999
E0152	Walker, Battery Powered, Wheeled, Folding, Adjustable Or Fixed Height	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0170	Commode Chair With Integrated Seat Lift Mechanism, Electric, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
E0172	Seat Lift Mechanism Placed Over Or On Top Of Toilet, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0183	Powered Pressure Reducing Underlay/Pad, Alternating, With Pump, Includes Heavy Duty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
E0190	Positioning Cushion/Pillow/Wedge, Any Shape Or Size, Includes All Components And Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0210	Electric Heat Pad, Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0215	Electric Heat Pad, Moist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0217	Water Circulating Heat Pad With Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0218	Fluid Circulating Cold Pad With Pump, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0225	Hydrocollator Unit, Includes Pads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0231	Non-Contact Wound Warming Device (Temperature Control Unit, Ac Adapter And Power Cord) For Use With Warming Card And Wound Cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0232	Warming Card For Use With The Non Contact Wound Warming Device And Non Contact Wound Warming Wound Cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0236	Pump For Water Circulating Pad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

E0239	Hydrocollator Unit, Portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0241	Bath Tub Wall Rail, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0242	Bath Tub Rail, Floor Base	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0243	Toilet Rail, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0249	Pad For Water Circulating Heat Unit, For Replacement Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0270	Hospital Bed, Institutional Type Includes: Oscillating, Circulating And Stryker Frame, With Mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0273	Bed Board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0274	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
E0315	Bed Accessory: Board, Table, Or Support Device, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0316	Safety Enclosure Frame/Canopy For Use With Hospital Bed, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0328	Hospital Bed, Pediatric, Manual, 360 Degree Side Enclosures, Top Of Headboard,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
E0329	Hospital Bed, Pediatric, Electric Or Semi-Electric, 360 Degree Side Enclosures,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
E0350	Control Unit For Electronic Bowel Irrigation/Evacuation System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0352	Disposable Pack (Water Reservoir Bag, Speculum, Valving Mechanism And Collection Bag/Box) For Use With The Electronic Bowel Irrigation/Evacuation System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0445	Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E0446	Topical Oxygen Delivery System, Not Otherwise Specified, Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0468	Home Ventilator, Dual-Function Respiratory Device, Also Performs Additional Function Of Cough Stimulation, Includes All Accessories, Components And Supplies For All Functions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0481	Intrapulmonary Percussive Ventilation System And Related Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E0482	Cough Stimulating Device, Alternating Positive And Negative Airway Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0483	High Frequency Chest Wall Oscillation System, With Full Anterior And/Or Posterior Thoracic Region Receiving Simultaneous External Oscillation, Includes All Accessories And Supplies, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0484	Oscillatory Positive Expiratory Pressure Device, Non-Electric, Any Type, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0485	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Adjustable Or Non-Adjustable, Prefabricated, Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
E0487	Spirometer, Electronic, Includes All Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0490	Power Source And Control Electronics Unit For Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle, Controlled By Hardware Remote	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
E0491	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle, Used In Conjunction With The Power Source And Control Electronics Unit, Controlled By Hardware Remote, 90-Day Supply	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
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.	1/1/2024	12/31/2999
E0493	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle, Used In Conjunction With The Power Source And Control Electronics Unit, Controlled By Phone Application, 90-Day Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0530	Electronic Positional Obstructive Sleep Apnea Treatment, With Sensor, Includes All Components And Accessories, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0616	Implantable Cardiac Event Recorder With Memory, Activator And Programmer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0617	External Defibrillator With Integrated Electrocardiogram Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0618	Apnea Monitor, Without Recording Feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0619	Apnea Monitor, With Recording Feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2020	12/31/2999
E0621	Sling Or Seat, Patient Lift, Canvas Or Nylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

E0625	Patient Lift, Bathroom Or Toilet, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0627	Seat Lift Mechanism, Electric, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0629	Seat Lift Mechanism, Non-Electric, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0630	Patient Lift, Hydraulic Or Mechanical, Includes Any Seat, Sling, Strap(S) Or Pad(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
E0635	Patient Lift, Electric With Seat Or Sling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0636	Multipositional Patient Support System, With Integrated Lift, Patient Accessible Controls	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
E0639	Patient Lift, Moveable From Room To Room With Disassembly And Reassembly, Includes All Components/Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0640	Patient Lift, Fixed System, Includes All Components/Accessories	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
E0650	Pneumatic Compressor, Non-Segmental Home Model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0651	Pneumatic Compressor, Segmental Home Model Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0652	Pneumatic Compressor, Segmental Home Model With Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0655	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0656	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E0657	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0660	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0665	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0666	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0667	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0668	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0669	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0670	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Integrated, 2 Full Legs And Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0671	Segmental Gradient Pressure Pneumatic Appliance, Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0672	Segmental Gradient Pressure Pneumatic Appliance, Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0673	Segmental Gradient Pressure Pneumatic Appliance, Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0675	Pneumatic Compression Device, High Pressure, Rapid Inflation/Deflation Cycle, For Arterial Insufficiency (Unilateral Or Bilateral System)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
E0676	Intermittent Limb Compression Device (Includes All Accessories), Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0677	Non-Pneumatic Sequential Compression Garment, Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
E0678	Non-Pneumatic Sequential Compression Garment, Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0679	Non-Pneumatic Sequential Compression Garment, Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

E0680	Non-Pneumatic Compression Controller With Sequential Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0681	Non-Pneumatic Compression Controller Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0682	Non-Pneumatic Sequential Compression Garment, Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0691	Ultraviolet Light Therapy System, Includes Bulbs/Lamps, Timer And Eye Protection; Treatment Area 2 Square Feet Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2015	12/31/2999
E0692	Ultraviolet Light Therapy System Panel, Includes Bulbs/Lamps, Timer And Eye Protection, 4 Foot Panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2015	12/31/2999
E0693	Ultraviolet Light Therapy System Panel, Includes Bulbs/Lamps, Timer And Eye Protection, 6 Foot Panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2015	12/31/2999
E0694	Ultraviolet Multidirectional Light Therapy System In 6 Foot Cabinet, Includes Bulbs/Lamps, Timer And Eye Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2015	12/31/2999
E0720	Transcutaneous Electrical Nerve Stimulation (Tens) Device, Two Lead, Localized Stimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device, Four Or More Leads, For Multiple Nerve Stimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2019	12/31/2999
E0732	Cranial Electrotherapy Stimulation (Ces) System, Any Type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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.	1/1/2024	12/31/2999
E0734	External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
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.	1/1/2024	12/31/2999
E0736	Transcutaneous Tibial Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0739	Rehabilitation System With Interactive Interface Providing Active Assistance In Rehabilitation Therapy, Includes All Components And Accessories, Motors, Microprocessors, Sensors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

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).	2/15/2015	12/31/2999
E0744	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0745	Neuromuscular Stimulator, Electronic Shock Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0746	Electromyography (Emg), Biofeedback Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
E0747	Osteogenesis Stimulator, Electrical, Non-Invasive, Other Than Spinal Applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0748	Osteogenesis Stimulator, Electrical, Non-Invasive, Spinal Applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0749	Osteogenesis Stimulator, Electrical, Surgically Implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0760	Osteogenesis Stimulator, Low Intensity Ultrasound, Non-Invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0761	Non-Thermal Pulsed High Frequency Radiowaves, High Peak Power Electromagnetic Energy Treatment Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0762	Transcutaneous Electrical Joint Stimulation Device System, Includes All Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0764	Functional Neuromuscular Stimulation, Transcutaneous Stimulation Of Sequential Muscle Groups Of Ambulation With Computer Control, Used For Walking By Spinal Cord Injured, Entire System, After Completion Of Training Program	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
E0765	Fda Approved Nerve Stimulator, With Replaceable Batteries, For Treatment Of Nausea And Vomiting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0766	Electrical Stimulation Device Used For Cancer Treatment, Includes All Accessories, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E0769	Electrical Stimulation Or Electromagnetic Wound Treatment Device, Not Otherwise Classified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
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.	9/1/2020	12/31/2999
E0784	External Ambulatory Infusion Pump, Insulin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E0787	External Ambulatory Infusion Pump, Insulin, Dosage Rate Adjustment Using Therapeutic Continuous Glucose Sensing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
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).	2/15/2015	12/31/2999
E0840	Traction Frame, Attached To Headboard, Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0849	Traction Equipment, Cervical, Free-Standing Stand/Frame, Pneumatic, Applying Traction Force To Other Than Mandible	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0850	Traction Stand, Free Standing, Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0855	Cervical Traction Equipment Not Requiring Additional Stand Or Frame	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0856	Cervical Traction Device, With Inflatable Air Bladder(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0860	Traction Equipment, Overdoor, Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0890	Traction Frame, Attached To Footboard, Pelvic Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0935	Continuous Passive Motion Exercise Device For Use On Knee Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0936	Continuous Passive Motion Exercise Device For Use Other Than Knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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).	2/15/2015	12/31/2999
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
E0950	Wheelchair Accessory, Tray, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0955	Wheelchair Accessory, Headrest, Cushioned, Any Type, Including Fixed Mounting Hardware, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0958	Manual Wheelchair Accessory, One-Arm Drive Attachment, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999

E0961	Manual Wheelchair Accessory, Wheel Lock Brake Extension (Handle), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E0968	Commode Seat, Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E0969	Narrowing Device, Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0971	Manual Wheelchair Accessory, Anti-Tipping Device, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E0973	Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E0974	Manual Wheelchair Accessory, Anti-Rollback Device, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E0981	Wheelchair Accessory, Seat Upholstery, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0982	Wheelchair Accessory, Back Upholstery, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0983	Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Joystick Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0984	Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Tiller Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E0985	Wheelchair Accessory, Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0986	Manual Wheelchair Accessory, Push-Rim Activated Power Assist System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0988	Manual Wheelchair Accessory, Lever-Activated, Wheel Drive, Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0990	Wheelchair Accessory, Elevating Leg Rest, Complete Assembly, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E0992	Manual Wheelchair Accessory, Solid Seat Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1002	Wheelchair Accessory, Power Seating System, Tilt Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E1003	Wheelchair Accessory, Power Seating System, Recline Only, Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1004	Wheelchair Accessory, Power Seating System, Recline Only, With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1005	Wheelchair Accessory, Power Seatng System, Recline Only, With Power Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1006	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1007	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1008	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Power Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1009	Wheelchair Accessory, Addition To Power Seating System, Mechanically Linked Leg Elevation System, Including Pushrod And Leg Rest, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1010	Wheelchair Accessory, Addition To Power Seating System, Power Leg Elevation System, Including Leg Rest, Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1012	Wheelchair Accessory, Addition To Power Seating System, Center Mount Power Elevating Leg Rest/Platform, Complete System, Any Type, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
E1014	Reclining Back, Addition To Pediatric Size Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E1028	Wheelchair Accessory, Manual Swingaway, Retractable Or Removable Mounting Hardware For Joystick, Other Control Interface Or Positioning Accessory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1031	Rollabout Chair, Any And All Types With Castors 5 Or Greater	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1035	Multi-Positional Patient Transfer System, With Integrated Seat, Operated By Care Giver, Patient Weight Capacity Up To And Including 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1036	Multi-Positional Patient Transfer System, Extra-Wide, With Integrated Seat, Operated By Caregiver, Patient Weight Capacity Greater Than 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1037	Transport Chair, Pediatric Size	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1038	Transport Chair, Adult Size, 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.	6/1/2015	12/31/2999

E1039	Transport Chair, Adult Size, Heavy Duty, Patient Weight Capacity Greater Than 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1050	Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1060	Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1070	Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1083	Hemi-Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1084	Hemi-Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1085	Hemi-Wheelchair, Fixed Full Length Arms, Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length, Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1087	High Strength Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1088	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1089	High Strength Lightweight Wheelchair, Fixed Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1090	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1092	Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1093	Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1100	Semi-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1110	Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

E1130	Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1140	Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1150	Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1160	Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
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.	6/1/2015	12/31/2999
E1170	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1171	Amputee Wheelchair, Fixed Full Length Arms, Without Footrests Or Legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1172	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Without Footrests Or Legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1180	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1190	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1195	Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1200	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1220	Wheelchair; Specially Sized Or Constructed, (Indicate Brand Name, Model Number, If Any) And Justification	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1221	Wheelchair With Fixed Arm, Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1222	Wheelchair With Fixed Arm, Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1223	Wheelchair With Detachable Arms, Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

E1224	Wheelchair With Detachable Arms, Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1225	Wheelchair Accessory, Manual Semi-Reclining Back, (Recline Greater Than 15 Degrees, But Less Than 80 Degrees), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1226	Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80 Degrees), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1227	Special Height Arms For Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1228	Special Back Height For Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1229	Wheelchair, Pediatric Size, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1230	Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name And Model Number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1231	Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1232	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1233	Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1234	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1235	Wheelchair, Pediatric Size, Rigid, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1236	Wheelchair, Pediatric Size, Folding, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1237	Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1238	Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1239	Power Wheelchair, Pediatric Size, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

E1240	Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away Detachable, Elevating Legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1250	Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1260	Lightweight Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1270	Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1280	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1285	Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1290	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1295	Heavy Duty Wheelchair, Fixed Full Length Arms, Elevating Legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E1296	Special Wheelchair Seat Height From Floor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1297	Special Wheelchair Seat Depth, By Upholstery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1298	Special Wheelchair Seat Depth And/Or Width, By Construction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E1300	Whirlpool, Portable (Overtub Type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2015	12/31/2999
E1301	Whirlpool Tub, Walk-In, Portable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
E1310	Whirlpool, Non-Portable (Built-In Type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2015	12/31/2999
E1570	Adjustable Chair, For Esrd Patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
E1629	Tablo Hemodialysis System For The Billable Dialysis Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
E1632	Wearable Artificial Kidney, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
E1639	Scale, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

E1700	Jaw Motion Rehabilitation System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2024	12/31/2999
E1701	Replacement Cushions For Jaw Motion Rehabilitation System, Pkg. Of 6	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2024	12/31/2999
E1702	Replacement Measuring Scales For Jaw Motion Rehabilitation System, Pkg. Of 200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2024	12/31/2999
E1902	Communication Board, Non-Electronic Augmentative Or Alternative Communication Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E1905	Virtual Reality Cognitive Behavioral Therapy Device (Cbt), Including Pre-Programmed Therapy Software	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	12/31/2999
E2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic Fluid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E2201	Manual Wheelchair Accessory, Nonstandard Seat Frame, Width Greater Than Or Equal To 20 Inches And Less Than 24 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2202	Manual Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2203	Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 To Less Than 22 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2204	Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 22 To 25 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2206	Manual Wheelchair Accessory, Wheel Lock Assembly, Complete, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2207	Wheelchair Accessory, Crutch And Cane Holder, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E2209	Arm Trough, With Or Without Hand Support, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2211	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2212	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2213	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2214	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2215	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

E2216	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2217	Manual Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2218	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2219	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2220	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2221	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2222	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2228	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2230	Manual Wheelchair Accessory, Manual Standing System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2231	Manual Wheelchair Accessory, Solid Seat Support Base (Replaces Sling Seat), Includes Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2291	Back, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2292	Seat, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2293	Back, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2294	Seat, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2295	Manual Wheelchair Accessory, For Pediatric Size Wheelchair, Dynamic Seating Frame, Allows Coordinated Movement Of Multiple Positioning Features	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2298	Complex Rehabilitative Power Wheelchair Accessory, Power Seat Elevation System, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E2301	Wheelchair Accessory, Power Standing System, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

E2310	Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And One Power Seating System Motor, Including All Related Electronics, Indicator Feature, Mechanical Function Selection Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2311	Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors, Including All Related Electronics, Indicator Feature, Mechanical Function Selection Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2312	Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2313	Power Wheelchair Accessory, Harness For Upgrade To Expandable Controller,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2321	Power Wheelchair Accessory, Hand Control Interface, Remote Joystick, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2322	Power Wheelchair Accessory, Hand Control Interface, Multiple Mechanical Switches, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2323	Power Wheelchair Accessory, Specialty Joystick Handle For Hand Control Interface, Prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2324	Power Wheelchair Accessory, Chin Cup For Chin Control Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2325	Power Wheelchair Accessory, Sip And Puff Interface, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Manual Swingaway Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2326	Power Wheelchair Accessory, Breath Tube Kit For Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2327	Power Wheelchair Accessory, Head Control Interface, Mechanical, Proportional, Including All Related Electronics, Mechanical Direction Change Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2328	Power Wheelchair Accessory, Head Control Or Extremity Control Interface, Electronic, Proportional, Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2329	Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, Mechanical Direction Change Switch, Head Array, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
E2331	Power Wheelchair Accessory, Attendant Control, Proportional, Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E2340	Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2341	Power Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2342	Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 Or 21 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2343	Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 22-25 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2351	Power Wheelchair Accessory, Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2358	Power Wheelchair Accessory, Group 34 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2359	Power Wheelchair Accessory, Group 34 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2360	Power Wheelchair Accessory, 22 Nf Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2361	Power Wheelchair Accessory, 22Nf Sealed Lead Acid Battery, Each, (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2362	Power Wheelchair Accessory, Group 24 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2363	Power Wheelchair Accessory, Group 24 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2364	Power Wheelchair Accessory, U-1 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2365	Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2366	Power Wheelchair Accessory, Battery Charger, Single Mode, For Use With Only One Battery Type, Sealed Or Non-Sealed, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2367	Power Wheelchair Accessory, Battery Charger, Dual Mode, For Use With Either Battery Type, Sealed Or Non-Sealed, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2371	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2372	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999

E2373	Power Wheelchair Accessory, Hand Or Chin Control Interface, Compact Remote Joystick, Proportional, Including Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
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.	6/1/2015	12/31/2999
E2375	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2376	Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2377	Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Upgrade Provided At Initial Issue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2381	Power Wheelchair Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2382	Power Wheelchair Accessory, Tube For Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2383	Power Wheelchair Accessory, Insert For Pneumatic Drive Wheel Tire (Removable), Any Type, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2384	Power Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2385	Power Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2386	Power Wheelchair Accessory, Foam Filled Drive Wheel Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2387	Power Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2388	Power Wheelchair Accessory, Foam Drive Wheel Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2389	Power Wheelchair Accessory, Foam Caster Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2394	Power Wheelchair Accessory, Drive Wheel Excludes Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2395	Power Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999

E2397	Power Wheelchair Accessory, Lithium-Based Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2402	Negative Pressure Wound Therapy Electrical Pump, Stationary Or Portable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2500	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Less Than Or Equal To 8 Minutes Recording Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2502	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2504	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2506	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 40 Minutes Recording Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2508	Speech Generating Device, Synthesized Speech, Requiring Message Formulation By Spelling And Access By Physical Contact With The Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2510	Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2511	Speech Generating Software Program, For Personal Computer Or Personal Digital Assistant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2512	Accessory For Speech Generating Device, Mounting System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2599	Accessory For Speech Generating Device, Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
E2601	General Use Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2602	General Use Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2603	Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2604	Skin Protection Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2605	Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2606	Positioning Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2607	Skin Protection And Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E2608	Skin Protection And Positioning Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2609	Custom Fabricated Wheelchair Seat Cushion, Any Size	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2610	Wheelchair Seat Cushion, Powered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E2611	General Use Wheelchair Back Cushion, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2612	General Use Wheelchair Back Cushion, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2613	Positioning Wheelchair Back Cushion, Posterior, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2614	Positioning Wheelchair Back Cushion, Posterior, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2615	Positioning Wheelchair Back Cushion, Posterior-Lateral, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2616	Positioning Wheelchair Back Cushion, Posterior-Lateral, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2617	Custom Fabricated Wheelchair Back Cushion, Any Size, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2619	Replacement Cover For Wheelchair Seat Cushion Or Back Cushion, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
E2620	Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2621	Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2622	Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2623	Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2624	Skin Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

E2625	Skin Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
E2626	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2627	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2628	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2629	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2630	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension Support	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2631	Wheelchair Accessory, Addition To Mobile Arm Support, Elevating Proximal Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2632	Wheelchair Accessory, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E2633	Wheelchair Accessory, Addition To Mobile Arm Support, Supinator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
E3000	Speech Volume Modulation System, Any Type, Including All Components And Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
G0029	Tobacco Screening Not Performed Or Tobacco Cessation Intervention Not Provided During The Measurement Period Or In The Six Months Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0030	Patient Screened For Tobacco Use And Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling, Pharmacotherapy, Or Both), If Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0031	Palliative Care Services Given To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0032	Two Or More Antipsychotic Prescriptions Ordered For Patients Who Had A Diagnosis Of Schizophrenia, Schizoaffective Disorder, Or Bipolar Disorder On Or Between January 1 Of The Year Prior To The Measurement Period And The Index Prescription Start Date (Ipsd) For Antipsychotics	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0033	Two Or More Benzodiazepine Prescriptions Ordered For Patients Who Had A Diagnosis Of Seizure Disorders, Rapid Eye Movement Sleep Behavior Disorder, Benzodiazepine Withdrawal, Ethanol Withdrawal, Or Severe Generalized Anxiety Disorder On Or Between January 1 Of The Year Prior To The Measurement Period And The Ipsd For Benzodiazepines	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

G0034	Patients Receiving Palliative Care During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0035	Patient Has Any Emergency Department Encounter During The Performance Period With Place Of Service Indicator 23	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0036	Patient Or Care Partner Decline Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0037	On Date Of Encounter, Patient Is Not Able To Participate In Assessment Or Screening, Including Non-Verbal Patients, Delirious, Severely Aphasic, Severely Developmentally Delayed, Severe Visual Or Hearing Impairment And For Those Patients, No Knowledgeable Informant Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0038	Clinician Determines Patient Does Not Require Referral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0039	Patient Not Referred, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0040	Patient Already Receiving Physical/Occupational/Speech/Recreational Therapy During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0041	Patient And/Or Care Partner Decline Referral	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0042	Referral To Physical, Occupational, Speech, Or Recreational Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0043	Patients With Mechanical Prosthetic Heart Valve	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0044	Patients With Moderate Or Severe Mitral Stenosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0045	Clinical Follow-Up And Mrs Score Assessed At 90 Days Following Endovascular Stroke Intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0046	Clinical Follow-Up And Mrs Score Not Assessed At 90 Days Following Endovascular Stroke Intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0047	Pediatric Patient With Minor Blunt Head Trauma And Pecarn Prediction Criteria Are Not Assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0048	Patients Who Receive Palliative Care Services Any Time During The Intake Period Through The End Of The Measurement Year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0049	With Maintenance Hemodialysis (In-Center And Home Hd) For The Complete Reporting Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0050	Patients With A Catheter That Have Limited Life Expectancy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0051	Patients Under Hospice Care In The Current Reporting Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0052	Patients On Peritoneal Dialysis For Any Portion Of The Reporting Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0053	Advancing Rheumatology Patient Care Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0054	Coordinating Stroke Care To Promote Prevention And Cultivate Positive Outcomes Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0055	Advancing Care For Heart Disease Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0057	Proposed Adopting Best Practices And Promoting Patient Safety Within Emergency Medicine Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

G0058	Improving Care For Lower Extremity Joint Repair Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0059	Patient Safety And Support Of Positive Experiences With Anesthesia Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0060	Allergy/Immunology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0061	Anesthesiology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0062	Audiology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0063	Cardiology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0064	Certified Nurse Midwife Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0065	Chiropractic Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0066	Clinical Social Work Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0067	Dentistry Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G0068	Professional Services For The Administration Of Anti-Infective, Pain Management, Chelation, Pulmonary Hypertension, Inotropic, Or Other Intravenous Infusion Drug Or Biological (Excluding Chemotherapy Or Other Highly Complex Drug Or Biological) For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0069	Professional Services For The Administration Of Subcutaneous Immunotherapy Or Other Subcutaneous Infusion Drug Or Biological For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0070	Professional Services For The Administration Of Intravenous Chemotherapy Or Other Intravenous Highly Complex Drug Or Biological Infusion For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0076	Brief (20 Minutes) Care Management Home Visit For A New Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0077	Limited (30 Minutes) Care Management Home Visit For A New Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0078	Moderate (45 Minutes) Care Management Home Visit For A New Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0079	Comprehensive (60 Minutes) Care Management Home Visit For A New Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

G0080	Extensive (75 Minutes) Care Management Home Visit For A New Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0081	Brief (20 Minutes) Care Management Home Visit For An Existing Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0082	Limited (30 Minutes) Care Management Home Visit For An Existing Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0083	Moderate (45 Minutes) Care Management Home Visit For An Existing Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0084	Comprehensive (60 Minutes) Care Management Home Visit For An Existing Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0085	Extensive (75 Minutes) Care Management Home Visit For An Existing Patient. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0086	Limited (30 Minutes) Care Management Home Care Plan Oversight. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0087	Comprehensive (60 Minutes) Care Management Home Care Plan Oversight. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
G0088	Professional Services, Initial Visit, For The Administration Of Anti-Infective, Pain Management, Chelation, Pulmonary Hypertension, Inotropic, Or Other Intravenous Infusion Drug Or Biological (Excluding Chemotherapy Or Other Highly Complex Drug Or Biological) For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G0089	Professional Services, Initial Visit, For The Administration Of Subcutaneous Immunotherapy Or Other Subcutaneous Infusion Drug Or Biological For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G0090	Professional Services, Initial Visit, For The Administration Of Intravenous Chemotherapy Or Other Highly Complex Infusion Drug Or Biological For Each Infusion Drug Administration Calendar Day In The Individual'S Home, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G0138	Intravenous Infusion Of Cipaglucosidase Alfa-Atga, Including Provider/Supplier Acquisition And Clinical Supervision Of Oral Administration Of Miglustat In Preparation Of Receipt Of Cipaglucosidase Alfa-Atga	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

G0151	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0152	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0153	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0156	Services Of Home Health/Hospice Aide In Home Health Or Hospice Settings, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
G0157	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0158	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0159	Services Performed By A Qualified Physical Therapist, In The Home Health Setting, In The Establishment Or Delivery Of A Safe And Effective Physical Therapy Maintenance Program, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0160	Services Performed By A Qualified Occupational Therapist, In The Home Health Setting, In The Establishment Or Delivery Of A Safe And Effective Occupational Therapy Maintenance Program, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0161	Services Performed By A Qualified Speech-Language Pathologist, In The Home Health Setting, In The Establishment Or Delivery Of A Safe And Effective Speech-Language Pathology Maintenance Program, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
G0180	Physician Or Allowed Practitioner Certification For Medicare-Covered Home Health Services Under A Home Health Plan Of Care (Patient Not Present), Including Contacts With Home Health Agency And Review Of Reports Of Patient Status Required By Physicians And Allowed Practitioners To Affirm The Initial Implementation Of The Plan Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G0245	Initial Physician Evaluation And Management Of A Diabetic Patient With Diabetic Sensory Neuropathy Resulting In A Loss Of Protective Sensation (Lops) Which Must Include: (1) The Diagnosis Of Lops, (2) A Patient History, (3) A Physical Examination That Consists Of At Least The Following Elements: (A) Visual Inspection Of The Forefoot, Hindfoot And Toe Web Spaces, (B)Evaluation Of A Protective Sensation, (C) Evaluation Of Foot Structure And Biomechanics, (D) Evaluation Of Vascular Status And Skin Integrity, And (E) Evaluation And Recommendation Of Footwear And (4) Patient Education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

G0246	Follow-Up Physician Evaluation And Management Of A Diabetic Patient With Diabetic Sensory Neuropathy Resulting In A Loss Of Protective Sensation (Lops) To Include At Least The Following: (1) A Patient History, (2) A Physical Examination That Includes: (A) Visual Inspection Of The Forefoot, Hindfoot And Toe Web Spaces, (B) Evaluation Of Protective Sensation, (C) Evaluation Of Foot Structure And Biomechanics, (D) Evaluation Of Vascular Status And Skin Integrity, And (E) Evaluation And Recommendation Of Footwear, And (3) Patient Education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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).	2/15/2015	12/31/2999
G0260	Injection Procedure For Sacroiliac Joint; Provision Of Anesthetic, Steroid And/Or Other Therapeutic Agent, With Or Without Arthrography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2020	12/31/2999
G0276	Blinded Procedure For Lumbar Stenosis, Percutaneous Image-Guided Lumbar Decompression (Pild) Or Placebo-Control, Performed In An Approved Coverage With Evidence Development (Ced) Clinical Trial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
G0276	Blinded Procedure For Lumbar Stenosis, Percutaneous Image-Guided Lumbar Decompression (Pild) Or Placebo-Control, Performed In An Approved Coverage With Evidence Development (Ced) Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999
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.	1/1/2015	12/31/2999
G0281	Electrical Stimulation, (Unattended), To One Or More Areas, For Chronic Stage Iii And Stage Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers, And Venous Statsis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care, As Part Of A Therapy Plan Of Care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
G0282	Electrical Stimulation, (Unattended), To One Or More Areas, For Wound Care Other Than Described In G0281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
G0293	Noncovered Surgical Procedure(S) Using Conscious Sedation, Regional, General Or Spinal Anesthesia In A Medicare Qualifying Clinical Trial, Per Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G0294	Noncovered Procedure(S) Using Either No Anesthesia Or Local Anesthesia Only, In A Medicare Qualifying Clinical Trial, Per Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G0295	Electromagnetic Therapy, To One Or More Areas, For Wound Care Other Than Described In G0329 Or For Other Uses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
G0299	Direct Skilled Nursing Services Of A Registered Nurse (Rn) In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
G0300	Direct Skilled Nursing Services Of A License Practical Nurse (Lpn) In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999

G0310	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service, 5 To 15 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0311	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service, 16-30 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0312	Immunization Counseling By A Physician Or Other Qualify Ed Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service For Ages Under 21, 5 To 15 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0313	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service For Ages Under 21, 16-30 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0314	Immunization Counseling By A Physician Or Other Qualified Health Care Professional For Covid-19, Ages Under 21, 16-30 Mins Time (This Code Is Used For The Medicaid Early And Periodic Screening, Diagnostic, And Treatment Benefit (Epsdt)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0315	Immunization Counseling By A Physician Or Other Qualified Health Care Professional For Covid-19, Ages Under 21, 5-15 Mins Time (This Code Is Used For The Medicaid Early And Periodic Screening, Diagnostic, And Treatment Benefit (Epsdt)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/11/2022	12/31/2999
G0316	Prolonged Hospital Inpatient Or Observation Care Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional, With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99223, 99233, And 99236 For Hospital Inpatient Or Observation Care Evaluation And Management Services). (Do Not Report G0316 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358, 99359, 99418, 99415, 99416). (Do Not Report G0316 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
G0317	Prolonged Nursing Facility Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional, With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99306, 99310 For Nursing Facility Evaluation And Management Services). (Do Not Report G0317 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358, 99359, 99418). (Do Not Report G0317 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

G0318	Prolonged Home Or Residence Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional, With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99345, 99350 For Home Or Residence Evaluation And Management Services). (Do Not Report G0318 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358, 99359, 99417). (Do Not Report G0318 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
G0329	Electromagnetic Therapy, To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers And Venous Stasis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
G0330	Facility Services For Dental Rehabilitation Procedure(S) Performed On A Patient Who Requires Monitored Anesthesia (E.G., General, Intravenous Sedation (Monitored Anesthesia Care) And Use Of An Operating Room	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
G0333	Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G0341	Percutaneous Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0342	Laparoscopy For Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0343	Laparotomy For Islet Cell Transplant, Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0400	Home Sleep Test (Hst) With Type Iv Portable Monitor, Unattended; Minimum Of 3 Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
G0416	Surgical Pathology, Gross And Microscopic Examinations, For Prostate Needle Biopsy, Any Method	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0420	Face-To-Face Educational Services Related To The Care Of Chronic Kidney Disease; Individual, Per Session, Per One Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G0421	Face-To-Face Educational Services Related To The Care Of Chronic Kidney Disease; Group, Per Session, Per One Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
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.	9/1/2020	12/31/2999
G0428	Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G., Cmi, Collagen Scaffold, Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G., As A Result Of Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0448	Insertion Or Replacement Of A Permanent Pacing Cardioverter-Defibrillator System With Transvenous Lead(S), Single Or Dual Chamber With Insertion Of Pacing Electrode, Cardiac Venous System, For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
G0455	Preparation With Instillation Of Fecal Microbiota By Any Method, Including Assessment Of Donor Specimen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2016	12/31/2999
G0460	Autologous Platelet Rich Plasma Or Other Blood-Derived Product For Non-Diabetic Chronic Wounds/Ulcers, Including As Applicable Phlebotomy, Centrifugation Or Mixing, And All Other Preparatory Procedures, Administration And Dressings, Per Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
G0465	Autologous Platelet Rich Plasma (Prp) Or Other Blood-Derived Product For Diabetic Chronic Wounds/Ulcers, Using An Fda-Cleared Device For This Indication, (Includes As Applicable Administration, Dressings, Phlebotomy, Centrifugation Or Mixing, And All Other Preparatory Procedures, Per Treatment)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
G0490	Face-To-Face Home Health Nursing Visit By A Rural Health Clinic (Rhc) Or Federally Qualified Health Center (Fqhc) In An Area With A Shortage Of Home Health Agencies. (Services Limited To Rn Or Lpn Only).	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2016	12/31/2999
G0493	Skilled Services Of A Registered Nurse (Rn) For The Observation And Assessment Of The Patient'S Condition, Each 15 Minutes (The Change In The Patient'S Condition Requires Skilled Nursing Personnel To Identify And Evaluate The Patient'S Need For Possible Modification Of Treatment In The Home Health Or Hospice Setting)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
G0494	Skilled Services Of A Licensed Practical Nurse (Lpn) For The Observation And Assessment Of The Patient'S Condition, Each 15 Minutes (The Change In The Patient'S Condition Requires Skilled Nursing Personnel To Identify And Evaluate The Patient'S Need For Possible Modification Of Treatment In The Home Health Or Hospice Setting)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
G0495	Skilled Services Of A Registered Nurse (Rn), In The Training And/Or Education Of A Patient Or Family Member, In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
G0496	Skilled Services Of A Licensed Practical Nurse (Lpn), In The Training And/Or Education Of A Patient Or Family Member, In The Home Health Or Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
G0501	Resource-Intensive Services For Patients For Whom The Use Of Specialized Mobility-Assistive Technology (Such As Adjustable Height Chairs Or Tables, Patient Lift, And Adjustable Padded Leg Supports) Is Medically Necessary And Used During The Provision Of An Office/Outpatient, Evaluation And Management Visit (List Separately In Addition To Primary Service)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G0516	Insertion Of Non-Biodegradable Drug Delivery Implants, 4 Or More (Services For Subdermal Rod Implant)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999

G0517	Removal Of Non-Biodegradable Drug Delivery Implants, 4 Or More (Services For Subdermal Implants)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
G0518	Removal With Reinsertion, Non-Biodegradable Drug Delivery Implants, 4 Or More (Services For Subdermal Implants)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
G0913	Improvement In Visual Function Achieved Within 90 Days Following Cataract Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G0914	Patient Care Survey Was Not Completed By Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G0915	Improvement In Visual Function Not Achieved Within 90 Days Following Cataract Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G0916	Satisfaction With Care Achieved Within 90 Days Following Cataract Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G0917	Patient Care Survey Was Not Completed By Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G1001	Clinical Decision Support Mechanism Evicore, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1002	Clinical Decision Support Mechanism Medcurrent, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1003	Clinical Decision Support Mechanism Medicalis, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1004	Clinical Decision Support Mechanism National Decision Support Company, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1007	Clinical Decision Support Mechanism Aim Specialty Health, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1008	Clinical Decision Support Mechanism Cranberry Peak, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1010	Clinical Decision Support Mechanism Stanson, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1011	Clinical Decision Support Mechanism, Qualified Tool Not Otherwise Specified, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G1012	Clinical Decision Support Mechanism Agilemd, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1013	Clinical Decision Support Mechanism Evidencecare Imagingcare, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1014	Clinical Decision Support Mechanism Inveniqa Semantic Answers In Medicine, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1015	Clinical Decision Support Mechanism Reliant Medical Group, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1016	Clinical Decision Support Mechanism Speed Of Care, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1017	Clinical Decision Support Mechanism Healthhelp, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1018	Clinical Decision Support Mechanism Infinx, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999

G1019	Clinical Decision Support Mechanism Logicnets, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2020	12/31/2999
G1020	Clinical Decision Support Mechanism Curbside Clinical Augmented Workflow, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
G1021	Clinical Decision Support Mechanism Ehealthline Clinical Decision Support Mechanism, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
G1022	Clinical Decision Support Mechanism Intermountain Clinical Decision Support Mechanism, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
G1023	Clinical Decision Support Mechanism Persivia Clinical Decision Support, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
G1024	Clinical Decision Support Mechanism Radrite, As Defined By The Medicare Appropriate Use Criteria Program	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G1025	Patient-Months Where There Are More Than One Medicare Capitated Payment (Mcp) Provider Listed For The Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G1026	The Number Of Adult Patient-Months In The Denominator Who Were On Maintenance Hemodialysis Using A Catheter Continuously For Three Months Or Longer Under The Care Of The Same Practitioner Or Group Partner As Of The Last Hemodialysis Session Of The Reporting Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G1027	The Number Of Adult Patient-Months In The Denominator Who Were On Maintenance Hemodialysis Under The Care Of The Same Practitioner Or Group Partner As Of The Last Hemodialysis Session Of The Reporting Month Using A Catheter Continuously For Less Than Three Months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G2000	Blinded Administration Of Convulsive Therapy Procedure, Either Electroconvulsive Therapy (Ect, Current Covered Gold Standard) Or Magnetic Seizure Therapy (Mst, Non-Covered Experimental Therapy), Performed In An Approved Ide-Based Clinical Trial, Per Treatment Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	8/1/2018	12/31/2999
G2001	Brief (20 Minutes) In-Home Visit For A New Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2002	Limited (30 Minutes) In-Home Visit For A New Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2003	Moderate (45 Minutes) In-Home Visit For A New Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999

G2004	Comprehensive (60 Minutes) In-Home Visit For A New Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2005	Extensive (75 Minutes) In-Home Visit For A New Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2006	Brief (20 Minutes) In-Home Visit For An Existing Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2007	Limited (30 Minutes) In-Home Visit For An Existing Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2008	Moderate (45 Minutes) In-Home Visit For An Existing Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2009	Comprehensive (60 Minutes) In-Home Visit For An Existing Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
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.	1/1/2019	12/31/2999
G2013	Extensive (75 Minutes) In-Home Visit For An Existing Patient Post-Discharge. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2014	Limited (30 Minutes) Care Plan Oversight. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility And No More Than 9 Times.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999

G2015	Comprehensive (60 Mins) Home Care Plan Oversight. For Use Only In A Medicare-Approved Cmmi Model. (Services Must Be Furnished Within A Beneficiary'S Home, Domiciliary, Rest Home, Assisted Living And/Or Nursing Facility Within 90 Days Following Discharge From An Inpatient Facility.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2019	12/31/2999
G2020	Services For High Intensity Clinical Services Associated With The Initial Engagement And Outreach Of Beneficiaries Assigned To The Sip Component Of The Pcf Model (Do Not Bill With Chronic Care Management Codes)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2021	12/31/2999
G2021	Health Care Practitioners Rendering Treatment In Place (Tip)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2022	A Model Participant (Ambulance Supplier/Provider), The Beneficiary Refuses Services Covered Under The Model (Transport To An Alternate Destination/Treatment In Place)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2025	Payment For A Telehealth Distant Site Service Furnished By A Rural Health Clinic (Rhc) Or Federally Qualified Health Center (Fqhc) Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2081	Patients Age 66 And Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With A Pos Code 32, 33, 34, 54 Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2082	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Up To 56 Mg Of Esketamine Nasal Self-Administration, Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
G2083	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Greater Than 56 Mg Esketamine Nasal Self-Administration, Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
G2090	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2091	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2092	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Or Angiotensin Receptor-Neprilysin Inhibitor (Arni) Therapy Prescribed Or Currently Being Taken	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2093	Documentation Of Medical Reason(S) For Not Prescribing Ace Inhibitor Or Arb Or Arni Therapy (E.G., Hypotensive Patients Who Are At Immediate Risk Of Cardiogenic Shock, Hospitalized Patients Who Have Experienced Marked Azotemia, Allergy, Intolerance, Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

G2094	Documentation Of Patient Reason(S) For Not Prescribing Ace Inhibitor Or Arb Or Arni Therapy (E.G., Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2096	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Or Angiotensin Receptor-Neprilysin Inhibitor (Arni) Therapy Was Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2097	Episodes Where The Patient Had A Competing Diagnosis On Or Within Three Days After The Episode Date (E.G., Intestinal Infection, Pertussis, Bacterial Infection, Lyme Disease, Otitis Media, Acute Sinusitis, Chronic Sinusitis, Infection Of The Adenoids, Prostatitis, Cellulitis, Mastoiditis, Or Bone Infections, Acute Lymphadenitis, Impetigo, Skin Staph Infections, Pneumonia/Gonococcal Infections, Venereal Disease (Syphilis, Chlamydia, Inflammatory Diseases [Female Reproductive Organs]), Infections Of The Kidney, Cystitis Or Uti)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2098	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2099	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2100	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2101	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2105	Patient Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With Pos Code 32, 33, 34, 54 Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2106	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

G2107	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2112	Patient Receiving <=5 Mg Daily Prednisone (Or Equivalent), Or Ra Activity Is Worsening, Or Glucocorticoid Use Is For Less Than 6 Months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2113	Patient Receiving >5 Mg Daily Prednisone (Or Equivalent) For Longer Than 6 Months, And Improvement Or No Change In Disease Activity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2115	Patients 66 - 80 Years Of Age With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2116	Patients 66 - 80 Years Of Age With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2118	Patients 81 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2121	Depression, Anxiety, Apathy, And Psychosis Assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2122	Depression, Anxiety, Apathy, And Psychosis Not Assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2125	Patients 81 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Six Months Prior To The Measurement Period Through December 31 Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2126	Patients 66 - 80 Years Of Age With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2127	Patients 66 ? 80 Years Of Age With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2128	Documentation Of Medical Reason(S) For Not On A Daily Aspirin Or Other Antiplatelet (E.G. History Of Gastrointestinal Bleed, Intra-Cranial Bleed, Blood Disorders, Idiopathic Thrombocytopenic Purpura (Itp), Gastric Bypass Or Documentation Of Active Anticoagulant Use During The Measurement Period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2129	Procedure-Related Bp'S Not Taken During An Outpatient Visit. Examples Include Same Day Surgery, Ambulatory Service Center, G.I. Lab, Dialysis, Infusion Center, Chemotherapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

G2136	Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively Was Less Than Or Equal To 3.0 Or Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated An Improvement Of 5.0 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2137	Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively Was Greater Than 3.0 And Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated Improvement Of Less Than 5.0 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2138	Back Pain As Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively Was Less Than Or Equal To 3.0 Or Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated An Improvement Of 5.0 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2139	Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively Was Greater Than 3.0 And Back Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated Improvement Of Less Than 5.0 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2140	Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively Was Less Than Or Equal To 3.0 Or Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated An Improvement Of 5.0 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2141	Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively Was Greater Than 3.0 And Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated Improvement Of Less Than 5.0 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2142	Functional Status Measured By The Oswestry Disability Index (Odi Version 2.1A) At One Year (9 To 15 Months) Postoperatively Was Less Than Or Equal To 22 Or Functional Status Measured By The Odi Version 2.1A Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated An Improvement Of 30 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2143	Functional Status Measured By The Oswestry Disability Index (Odi Version 2.1A) At One Year (9 To 15 Months) Postoperatively Was Greater Than 22 And Functional Status Measured By The Odi Version 2.1A Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated An Improvement Of Less Than 30 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

G2144	Functional Status Measured By The Oswestry Disability Index (Odi Version 2.1A) At Three Months (6 ? 20 Weeks) Postoperatively Was Less Than Or Equal To 22 Or Functional Status Measured By The Odi Version 2.1A Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated An Improvement Of 30 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2145	Functional Status Measured By The Oswestry Disability Index (Odi Version 2.1A) At Three Months (6 - 20 Weeks) Postoperatively Was Greater Than 22 And Functional Status Measured By The Odi Version 2.1A Within Three Months Preoperatively And At Three Months (6 - 20 Weeks) Postoperatively Demonstrated An Improvement Of Less Than 30 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2146	Leg Pain As Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively Was Less Than Or Equal To 3.0 Or Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated An Improvement Of 5.0 Points Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2147	Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively Was Greater Than 3.0 And Leg Pain Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale Within Three Months Preoperatively And At One Year (9 To 15 Months) Postoperatively Demonstrated Improvement Of Less Than 5.0 Points	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2148	Multimodal Pain Management Was Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2149	Documentation Of Medical Reason(S) For Not Using Multimodal Pain Management (E.G., Allergy To Multiple Classes Of Analgesics, Intubated Patient, Hepatic Failure, Patient Reports No Pain During Pacu Stay, Other Medical Reason(S))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2150	Multimodal Pain Management Was Not Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2151	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2152	Residual Score For The Neck Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2167	Residual Score For The Neck Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
G2168	Services Performed By A Physical Therapist Assistant In The Home Health Setting In The Delivery Of A Safe And Effective Physical Therapy Maintenance Program, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
G2169	Services Performed By An Occupational Therapist Assistant In The Home Health Setting In The Delivery Of A Safe And Effective Occupational Therapy Maintenance Program, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
G2172	All Inclusive Payment For Services Related To Highly Coordinated And Integrated Opioid Use Disorder (Oud) Treatment Services Furnished For The Demonstration Project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2021	12/31/2999

G2173	Uri Episodes Where The Patient Had A Comorbid Condition During The 12 Months Prior To Or On The Episode Date (E.G., Tuberculosis, Neutropenia, Cystic Fibrosis, Chronic Bronchitis, Pulmonary Edema, Respiratory Failure, Rheumatoid Lung Disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2174	Uri Episodes Where The Patient Is Taking Antibiotics (Table 1) In The 30 Days Prior To The Episode Date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2175	Episodes Where The Patient Had A Comorbid Condition During The 12 Months Prior To Or On The Episode Date (E.G., Tuberculosis, Neutropenia, Cystic Fibrosis, Chronic Bronchitis, Pulmonary Edema, Respiratory Failure, Rheumatoid Lung Disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2176	Outpatient, Ed, Or Observation Visits That Result In An Inpatient Admission	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2177	Acute Bronchitis/Bronchiolitis Episodes When The Patient Had A New Or Refill Prescription Of Antibiotics (Table 1) In The 30 Days Prior To The Episode Date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2178	Clinician Documented That Patient Was Not An Eligible Candidate For Lower Extremity Neurological Exam Measure, For Example Patient Bilateral Amputee; Patient Has Condition That Would Not Allow Them To Accurately Respond To A Neurological Exam (Dementia, Alzheimer'S, Etc.); Patient Has Previously Documented Diabetic Peripheral Neuropathy With Loss Of Protective Sensation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2179	Clinician Documented That Patient Had Medical Reason For Not Performing Lower Extremity Neurological Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2180	Clinician Documented That Patient Was Not An Eligible Candidate For Evaluation Of Footwear As Patient Is Bilateral Lower Extremity Amputee	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2181	Bmi Not Documented Due To Medical Reason Or Patient Refusal Of Height Or Weight Measurement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2182	Patient Receiving First-Time Biologic And/Or Immune Response Modifier Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2183	Documentation Patient Unable To Communicate And Informant Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2184	Patient Does Not Have A Caregiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2185	Documentation Caregiver Is Trained And Certified In Dementia Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2186	Patient /Caregiver Dyad Has Been Referred To Appropriate Resources And Connection To Those Resources Is Confirmed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2187	Patients With Clinical Indications For Imaging Of The Head: Head Trauma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2188	Patients With Clinical Indications For Imaging Of The Head: New Or Change In Headache Above 50 Years Of Age	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2189	Patients With Clinical Indications For Imaging Of The Head: Abnormal Neurologic Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2190	Patients With Clinical Indications For Imaging Of The Head: Headache Radiating To The Neck	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2191	Patients With Clinical Indications For Imaging Of The Head: Positional Headaches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2192	Patients With Clinical Indications For Imaging Of The Head: Temporal Headaches In Patients Over 55 Years Of Age	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

G2193	Patients With Clinical Indications For Imaging Of The Head: New Onset Headache In Pre-School Children Or Younger (<6 Years Of Age)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2194	Patients With Clinical Indications For Imaging Of The Head: New Onset Headache In Pediatric Patients With Disabilities For Which Headache Is A Concern As Inferred From Behavior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2195	Patients With Clinical Indications For Imaging Of The Head: Occipital Headache In Children	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2196	Patient Identified As An Unhealthy Alcohol User When Screened For Unhealthy Alcohol Use Using A Systematic Screening Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2197	Patient Screened For Unhealthy Alcohol Use Using A Systematic Screening Method And Not Identified As An Unhealthy Alcohol User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2199	Patient Not Screened For Unhealthy Alcohol Use Using A Systematic Screening Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2200	Patient Identified As An Unhealthy Alcohol User Received Brief Counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2202	Patient Did Not Receive Brief Counseling If Identified As An Unhealthy Alcohol User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2204	Patients Between 45 And 85 Years Of Age Who Received A Screening Colonoscopy During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2205	Patients With Pregnancy During Adjuvant Treatment Course	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2206	Patient Received Adjuvant Treatment Course Including Both Chemotherapy And Her2-Targeted Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2207	Reason For Not Administering Adjuvant Treatment Course Including Both Chemotherapy And Her2-Targeted Therapy (E.G. Poor Performance Status (Ecog 3-4; Karnofsky <=50), Cardiac Contraindications, Insufficient Renal Function, Insufficient Hepatic Function, Other Active Or Secondary Cancer Diagnoses, Other Medical Contraindications, Patients Who Died During Initial Treatment Course Or Transferred During Or After Initial Treatment Course)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2208	Patient Did Not Receive Adjuvant Treatment Course Including Both Chemotherapy And Her2-Targeted Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2209	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2210	Residual Score For The Neck Impairment Not Measured Because The Patient Did Not Complete The Neck Fs Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
G2250	Remote Assessment Of Recorded Video And/Or Images Submitted By An Established Patient (E.G., Store And Forward), Including Interpretation With Follow-Up With The Patient Within 24 Business Hours, Not Originating From A Related Service Provided Within The Previous 7 Days Nor Leading To A Service Or Procedure Within The Next 24 Hours Or Soonest Available Appointment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

G3002	Chronic Pain Management And Treatment, Monthly Bundle Including, Diagnosis; Assessment And Monitoring; Administration Of A Validated Pain Rating Scale Or Tool; The Development, Implementation, Revision, And/Or Maintenance Of A Person-Centered Care Plan That Includes Strengths, Goals, Clinical Needs, And Desired Outcomes; Overall Treatment Management; Facilitation And Coordination Of Any Necessary Behavioral Health Treatment; Medication Management; Pain And Health Literacy Counseling; Any Necessary Chronic Pain Related Crisis Care; And Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care, E.G. Physical Therapy And Occupational Therapy, Complementary And Integrative Approaches, And Community-Based Care, As Appropriate. Required Initial Face-To-Face Visit At Least 30 Minutes Provided By A Physician Or Other Qualified Health Professional; First 30 Minutes Personally Provided By Physician Or Other Qualified Health Care Professional, Per Calendar Month. (When Using G3002, 30 Minutes Must Be Met Or Exceeded.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
G3003	Each Additional 15 Minutes Of Chronic Pain Management And Treatment By A Physician Or Other Qualified Health Care Professional, Per Calendar Month. (List Separately In Addition To Code For G3002. When Using G3003, 15 Minutes Must Be Met Or Exceeded.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
G4000	Dermatology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4001	Diagnostic Radiology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4002	Electrophysiology Cardiac Specialist Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4003	Emergency Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4004	Endocrinology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4005	Family Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4006	Gastro-Enterology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4007	General Surgery Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4008	Geriatrics Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4009	Hospitalists Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4010	Infectious Disease Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4011	Internal Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4012	Interventional Radiology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4013	Mental/Behavioral And Psychiatry Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

G4014	Nephrology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4015	Neurology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4016	Neurosurgical Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4017	Nutrition/Dietician Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4018	Obstetrics/Gynecology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4019	Oncology/Hematology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4020	Ophthalmology/Optometry Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4021	Orthopedic Surgery Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4022	Otolaryngology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4023	Pathology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4024	Pediatrics Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4025	Physical Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4026	Physical Therapy/Occupational Therapy Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4027	Plastic Surgery Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4028	Podiatry Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4029	Preventive Medicine Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4030	Pulmonology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4031	Radiation Oncology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4032	Rheumatology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4033	Skilled Nursing Facility Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4034	Speech Language Pathology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4035	Thoracic Surgery Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4036	Urgent Care Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4037	Urology Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G4038	Vascular Surgery Mips Specialty Set	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

G8395	Left Ventricular Ejection Fraction (Lvef) >= 40% Or Documentation As Normal Or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8396	Left Ventricular Ejection Fraction (Lvef) Not Performed Or Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8397	Dilated Macular Or Fundus Exam Performed, Including Documentation Of The	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8399	Patient With Documented Results Of A Central Dual-Energy X-Ray Absorptiometry (Dxa) Ever Being Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8400	Patient With Central Dual-Energy X-Ray Absorptiometry (Dxa) Results Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8404	Lower Extremity Neurological Exam Performed And Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8405	Lower Extremity Neurological Exam Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8410	Footwear Evaluation Performed And Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8415	Footwear Evaluation Was Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8416	Clinician Documented That Patient Was Not An Eligible Candidate For Footwear	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8417	Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8418	Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8419	Bmi Documented Outside Normal Parameters, No Follow-Up Plan Documented, No Reason Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8420	Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8421	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8427	Eligible Clinician Attests To Documenting In The Medical Record They Obtained, Updated, Or Reviewed The Patient'S Current Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8428	Current List Of Medications Not Documented As Obtained, Updated, Or Reviewed By The Eligible Clinician, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8430	Documentation Of A Medical Reason(S) For Not Documenting, Updating, Or Reviewing The Patient'S Current Medications List (E.G., Patient Is In An Urgent Or Emergent Medical Situation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8431	Screening For Depression Is Documented As Being Positive And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8432	Depression Screening Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8433	Screening For Depression Not Completed, Documented Patient Or Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8450	Beta-Blocker Therapy Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8451	Beta-Blocker Therapy For Lvef <=40% Not Prescribed For Reasons Documented By The Clinician (E.G., Low Blood Pressure, Fluid Overload, Asthma, Patients Recently Treated With An Intravenous Positive Inotropic Agent, Allergy, Intolerance, Other Medical Reasons, Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8452	Beta-Blocker Therapy Not Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8465	High Or Very High Risk Of Recurrence Of Prostate Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8473	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8474	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed For Reasons Documented By The Clinician (E.G., Allergy, Intolerance, Pregnancy, Renal Failure Due To Ace Inhibitor, Diseases Of The Aortic Or Mitral Valve, Other Medical Reasons) Or (E.G., Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8475	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8476	Most Recent Blood Pressure Has A Systolic Measurement Of < 140 Mmhg And A Diastolic Measurement Of < 90 Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8477	Most Recent Blood Pressure Has A Systolic Measurement Of >=140 Mmhg And/Or A Diastolic Measurement Of >=90 Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8478	Blood Pressure Measurement Not Performed Or Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8482	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8483	Influenza Immunization Was Not Administered For Reasons Documented By Clinician (E.G., Patient Allergy Or Other Medical Reasons, Patient Declined Or Other Patient Reasons, Vaccine Not Available Or Other System Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8484	Influenza Immunization Was Not Administered, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8510	Screening For Depression Is Documented As Negative, A Follow-Up Plan Is Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8511	Screening For Depression Documented As Positive, Follow-Up Plan Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8535	Elder Maltreatment Screen Not Documented; Documentation That Patient Is Not Eligible For The Elder Maltreatment Screen At The Time Of The Encounter Related To One Of The Following Reasons: (1) Patient Refuses To Participate In The Screening And Has Reasonable Decisional Capacity For Self-Protection, Or (2) Patient Is In An Urgent Or Emergent Situation Where Time Is Of The Essence And To Delay Treatment To Perform The Screening Would Jeopardize The Patient'S Health Status	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8536	No Documentation Of An Elder Maltreatment Screen, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8539	Functional Outcome Assessment Documented As Positive Using A Standardized Tool And A Care Plan Based On Identified Deficiencies Is Documented Within Two Days Of The Functional Outcome Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8540	Functional Outcome Assessment Not Documented As Being Performed, Documentation The Patient Is Not Eligible For A Functional Outcome Assessment Using A Standardized Tool At The Time Of The Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8541	Functional Outcome Assessment Using A Standardized Tool Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8542	Functional Outcome Assessment Using A Standardized Tool Is Documented; No Functional Deficiencies Identified, Care Plan Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8543	Documentation Of A Positive Functional Outcome Assessment Using A Standardized Tool; Care Plan Not Documented Within Two Days Of Assessment, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8559	Patient Referred To A Physician (Preferably A Physician With Training In Disorders Of The Ear) For An Otologic Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8560	Patient Has A History Of Active Drainage From The Ear Within The Previous 90 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8561	Patient Is Not Eligible For The Referral For Otologic Evaluation For Patients With A History Of Active Drainage Measure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8562	Patient Does Not Have A History Of Active Drainage From The Ear Within The Previous 90 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8563	Patient Not Referred To A Physician (Preferably A Physician With Training In Disorders Of The Ear) For An Otologic Evaluation, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8564	Patient Was Referred To A Physician (Preferably A Physician With Training In Disorders Of The Ear) For An Otologic Evaluation, Reason Not Specified)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8565	Verification And Documentation Of Sudden Or Rapidly Progressive Hearing Loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8566	Patient Is Not Eligible For The Referral For Otologic Evaluation For Sudden Or Rapidly Progressive Hearing Loss Measure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8567	Patient Does Not Have Verification And Documentation Of Sudden Or Rapidly Progressive Hearing Loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8568	Patient Was Not Referred To A Physician (Preferably A Physician With Training In Disorders Of The Ear) For An Otologic Evaluation, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8569	Prolonged Postoperative Intubation (> 24 Hrs) Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8570	Prolonged Postoperative Intubation (> 24 Hrs) Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8575	Developed Postoperative Renal Failure Or Required Dialysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8576	No Postoperative Renal Failure/Dialysis Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8577	Re-Exploration Required Due To Mediastinal Bleeding With Or Without Tamponade, Graft Occlusion, Valve Dysfunction Or Other Cardiac Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8578	Re-Exploration Not Required Due To Mediastinal Bleeding With Or Without Tamponade, Graft Occlusion, Valve Dysfunction Or Other Cardiac Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8598	Aspirin Or Another Antiplatelet Therapy Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8599	Aspirin Or Another Antiplatelet Therapy Not Used, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8600	Iv Thrombolytic Therapy Initiated Within 4.5 Hours (<= 270 Minutes) Of Time Last Known Well	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8601	Iv Thrombolytic Therapy Not Initiated Within 4.5 Hours (<= 270 Minutes) Of Time Last Known Well For Reasons Documented By Clinician (E.G. Patient Enrolled In Clinical Trial For Stroke, Patient Admitted For Elective Carotid Intervention)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8602	Iv Thrombolytic Therapy Not Initiated Within 4.5 Hours (<= 270 Minutes) Of Time Last Known Well, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8633	Pharmacologic Therapy (Other Than Minerals/Vitamins) For Osteoporosis Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8635	Pharmacologic Therapy For Osteoporosis Was Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8647	Residual Score For The Knee Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8648	Residual Score For The Knee Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8650	Residual Score For The Knee Impairment Not Measured Because The Patient Did Not Complete The Lepf Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8651	Residual Score For The Hip Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8652	Residual Score For The Hip Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8654	Residual Score For The Hip Impairment Not Measured Because The Patient Did Not Complete The Lepf Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8655	Residual Score For The Lower Leg, Foot Or Ankle Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8656	Residual Score For The Lower Leg, Foot Or Ankle Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8658	Residual Score For The Lower Leg, Foot Or Ankle Impairment Not Measured Because The Patient Did Not Complete The Lepf Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8659	Residual Score For The Low Back Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8660	Residual Score For The Low Back Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8661	Risk-Adjusted Functional Status Change Residual Score For The Low Back Impairment Not Measured Because The Patient Did Not Complete The Fs Status Survey Near Discharge, Patient Not Appropriate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8662	Residual Score For The Low Back Impairment Not Measured Because The Patient Did Not Complete The Low Back Fs Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8663	Residual Score For The Shoulder Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8664	Residual Score For The Shoulder Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8666	Residual Score For The Shoulder Impairment Not Measured Because The Patient Did Not Complete The Shoulder Fs Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8667	Residual Score For The Elbow, Wrist Or Hand Impairment Successfully Calculated And The Score Was Equal To Zero (0) Or Greater Than Zero (> 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8668	Residual Score For The Elbow, Wrist Or Hand Impairment Successfully Calculated And The Score Was Less Than Zero (< 0)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8670	Residual Score For The Elbow, Wrist Or Hand Impairment Not Measured Because The Patient Did Not Complete The Elbow/Wrist/Hand Fs Prom At Initial Evaluation And/Or Near Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8694	Left Ventricular Ejection Fraction (Lvef) < = 40% Or Documentation Of Moderate Or Severe Lvsd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8708	Patient Not Prescribed Antibiotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8709	Uri Episodes When The Patient Had Competing Diagnoses On Or Three Days After The Episode Date (E.G., Intestinal Infection, Pertussis, Bacterial Infection, Lyme Disease, Otitis Media, Acute Sinusitis, Acute Pharyngitis, Acute Tonsillitis, Chronic Sinusitis, Infection Of The Pharynx/Larynx/Tonsils/Adenoids, Prostatitis, Cellulitis, Mastoiditis, Or Bone Infections, Acute Lymphadenitis, Impetigo, Skin Staph Infections, Pneumonia/Gonococcal Infections, Venereal Disease (Syphilis, Chlamydia, Inflammatory Diseases [Female Reproductive Organs]), Infections Of The Kidney, Cystitis Or Uti, And Acne)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8710	Patient Prescribed Antibiotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8711	Prescribed Antibiotic On Or Within 3 Days After The Episode Date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8712	Antibiotic Not Prescribed Or Dispensed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8721	Pt Category (Primary Tumor), Pn Category (Regional Lymph Nodes), And Histologic Grade Were Documented In Pathology Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8722	Documentation Of Medical Reason(S) For Not Including The Pt Category, The Pn Category Or The Histologic Grade In The Pathology Report (E.G., Re-Excision Without Residual Tumor; Non-Carcinomasanal Canal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8723	Specimen Site Is Other Than Anatomic Location Of Primary Tumor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8724	Pt Category, Pn Category And Histologic Grade Were Not Documented In The Pathology Report, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8733	Elder Maltreatment Screen Documented As Positive And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8734	Elder Maltreatment Screen Documented As Negative, Follow-Up Is Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8735	Elder Maltreatment Screen Documented As Positive, Follow-Up Plan Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8749	Absence Of Signs Of Melanoma (Tenderness, Jaundice, Localized Neurologic Signs Such As Weakness, Or Any Other Sign Suggesting Systemic Spread) Or Absence Of Symptoms Of Melanoma (Cough, Dyspnea, Pain, Paresthesia, Or Any Other Symptom Suggesting The Possibility Of Systemic Spread Of Melanoma)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8752	Most Recent Systolic Blood Pressure < 140Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8753	Most Recent Systolic Blood Pressure >= 140Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8754	Most Recent Diastolic Blood Pressure < 90Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8755	Most Recent Diastolic Blood Pressure >= 90Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8756	No Documentation Of Blood Pressure Measurement, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8783	Normal Blood Pressure Reading Documented, Follow-Up Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8785	Blood Pressure Reading Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8797	Specimen Site Other Than Anatomic Location Of Esophagus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8798	Specimen Site Other Than Anatomic Location Of Prostate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8806	Performance Of Trans-Abdominal Or Trans-Vaginal Ultrasound And Pregnancy Location Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8807	Trans-Abdominal Or Trans-Vaginal Ultrasound Not Performed For Reasons Documented By Clinician (E.G., Patient Has A Documented Intrauterine Pregnancy [Iup])	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8808	Trans-Abdominal Or Trans-Vaginal Ultrasound Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8815	Documented Reason In The Medical Records For Why The Statin Therapy Was Not Prescribed (I.E., Lower Extremity Bypass Was For A Patient With Non-Artherosclerotic Disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8816	Statin Medication Prescribed At Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8817	Statin Therapy Not Prescribed At Discharge, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8826	Patient Discharged To Home No Later Than Post-Operative Day #2 Following Evar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8833	Patient Not Discharged To Home By Post-Operative Day #2 Following Evar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8834	Patient Discharged To Home No Later Than Post-Operative Day #2 Following Cea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8838	Patient Not Discharged To Home By Post-Operative Day #2 Following Cea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8839	Sleep Apnea Symptoms Assessed, Including Presence Or Absence Of Snoring And Daytime Sleepiness	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8840	Documentation Of Reason(S) For Not Documenting An Assessment Of Sleep Symptoms (E.G., Patient Didn'T Have Initial Daytime Sleepiness, Patient Visited Between Initial Testing And Initiation Of Therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8841	Sleep Apnea Symptoms Not Assessed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8842	Apnea Hypopnea Index (Ahi), Respiratory Disturbance Index (Rdi) Or Respiratory Event Index (Rei) Documented Or Measured Within 2 Months Of Initial Evaluation For Suspected Obstructive Sleep Apnea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8843	Documentation Of Reason(S) For Not Measuring An Apnea Hypopnea Index (Ahi), A Respiratory Disturbance Index (Rdi), Or A Respiratory Event Index (Rei) Within 2 Months Of Initial Evaluation For Suspected Obstructive Sleep Apnea (E.G., Medical, Neurological, Or Psychiatric Disease That Prohibits Successful Completion Of A Sleep Study, Patients For Whom A Sleep Study Would Present A Bigger Risk Than Benefit Or Would Pose An Undue Burden, Dementia, Patients Who Decline Ahi/Rdi/Rei Measurement, Patients Who Had A Financial Reason For Not Completing Testing, Test Was Ordered But Not Completed, Patients Decline Because Their Insurance (Payer) Does Not Cover The Expense))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8844	Apnea Hypopnea Index (Ahi), Respiratory Disturbance Index (Rdi), Or Respiratory Event Index (Rei) Not Documented Or Measured Within 2 Months Of Initial Evaluation For Suspected Obstructive Sleep Apnea, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8845	Positive Airway Pressure Therapy Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8846	Moderate Or Severe Obstructive Sleep Apnea (Apnea Hypopnea Index (Ahi) Or Respiratory Disturbance Index (Rdi) Of 15 Or Greater)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8849	Documentation Of Reason(S) For Not Prescribing Positive Airway Pressure Therapy (E. G. , Patient Unable To Tolerate, Alternative Therapies Use, Patient Declined, Financial, Insurance Coverage)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8850	Positive Airway Pressure Therapy Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8851	Adherence To Therapy Was Assessed At Least Annually Through An Objective Informatics System Or Through Self-Reporting (If Objective Reporting Is Not Available, Documented)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8854	Documentation Of Reason(S) For Not Objectively Reporting Adherence To Evidence-Based Therapy (E.G., Patients Who Have Been Diagnosed With A Terminal Or Advanced Disease With An Expected Life Span Of Less Than 6 Months, Patients Who Decline Therapy, Patients Who Do Not Return For Follow-Up At Least Annually, Patients Unable To Access/Afford Therapy, Patient'S Insurance Will Not Cover Therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8855	Adherence To Therapy Was Not Assessed At Least Annually Through An Objective Informatics System Or Through Self-Reporting (If Objective Reporting Is Not Available), Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8856	Referral To A Physician For An Otologic Evaluation Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8857	Patient Is Not Eligible For The Referral For Otologic Evaluation Measure (E.G., Patients Who Are Already Under The Care Of A Physician For Acute Or Chronic Dizziness)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8858	Referral To A Physician For An Otologic Evaluation Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8863	Patients Not Assessed For Risk Of Bone Loss, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8864	Pneumococcal Vaccine Administered Or Previously Received	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8865	Documentation Of Medical Reason(S) For Not Administering Or Previously Receiving Pneumococcal Vaccine (E.G., Patient Allergic Reaction, Potential Adverse Drug Reaction)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8866	Documentation Of Patient Reason(S) For Not Administering Or Previously Receiving Pneumococcal Vaccine (E.G., Patient Refusal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8867	Pneumococcal Vaccine Not Administered Or Previously Received, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8869	Patient Has Documented Immunity To Hepatitis B And Initiating Anti-Tnf Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8875	Clinician Diagnosed Breast Cancer Preoperatively By A Minimally Invasive Biopsy Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8876	Documentation Of Reason(S) For Not Performing Minimally Invasive Biopsy To Diagnose Breast Cancer Properatively (E.G., Lesion Too Close To Skin, Implant, Chest Wall, Etc., Lesion Could Not Be Adequately Visualized For Needle Biopsy, Patient Condition Prevents Needle Biopsy [Weight, Breast Thickness, Etc.], Duct Excision Without Imaging Abnormality, Prophylactic Mastectomy, Reduction Mammoplasty, Excisional Biopsy Performed By Another Physician)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8877	Clinician Did Not Attempt To Achieve The Diagnosis Of Breast Cancer Preoperatively By A Minimally Invasive Biopsy Method, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8878	Sentinel Lymph Node Biopsy Procedure Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8880	Documentation Of Reason(S) Sentinel Lymph Node Biopsy Not Performed (E.G., Reasons Could Include But Not Limited To; Non-Invasive Cancer, Incidental Discovery Of Breast Cancer On Prophylactic Mastectomy, Incidental Discovery Of Breast Cancer On Reduction Mammoplasty, Pre-Operative Biopsy Proven Lymph Node (Ln) Metastases, Inflammatory Carcinoma, Stage 3 Locally Advanced Cancer, Recurrent Invasive Breast Cancer, Clinically Node Positive After Neoadjuvant Systemic Therapy, Patient Refusal After Informed Consent, Patient With Significant Age, Comorbidities, Or Limited Life Expectancy And Favorable Tumor; Adjuvant Systemic Therapy Unlikely To Change)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8881	Stage Of Breast Cancer Is Greater Than T1N0M0 Or T2N0M0	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8882	Sentinel Lymph Node Biopsy Procedure Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8907	Patient Documented Not To Have Experienced Any Of The Following Events: A Burn Prior To Discharge, A Fall Within The Facility, Wrong Site/Side/Patient/Procedure/Implant Event, A Hospital Transfer Or Hospital Admission Upon Discharge From The Facility.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8908	Patient Documented To Have Received A Burn Prior To Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8909	Patient Documented Not To Have Received A Burn Prior To Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8910	Patient Documented To Have Experienced A Fall Within Asc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8911	Patient Documented Not To Have Experienced A Fall Within Asc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8912	Patient Documented To Have Experienced A Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure Or Wrong Implant Event	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8913	Patient Documented Not To Have Experienced A Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure Or Wrong Implant Event	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8914	Patient Documented To Have Experienced A Hospital Transfer Or Hospital Admission Upon Discharge From Asc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8915	Patient Documented Not To Have Experienced A Hospital Transfer Or Hospital Admission Upon Discharge From Asc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8916	Patient With Preoperative Order For Iv Antibiotic Surgical Site Infection. (Ssi) Prophylaxis, Antibiotic Initiated On Time.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8917	Patient With Preoperative Order For Iv Antibiotic Surgical Site Infection. (Ssi) Prophylaxis, Antibiotic Not Initiated On Time.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8918	Patient Without Preoperative Order For Iv Antibiotic Surgical Site Infection. (Ssi) Prophylaxis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8923	Left Ventricular Ejection Fraction (Lvef) <= 40% Or Documentation Of Moderately Or Severely Depressed Left Ventricular Systolic Function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8924	Spirometry Results Documented (Fev1/Fvc < 70%)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8934	Left Ventricular Ejection Fraction (Lvef) <=40% Or Documentation Of Moderately Or Severely Depressed Left Ventricular Systolic Function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8935	Clinician Prescribed Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8936	Clinician Documented That Patient Was Not An Eligible Candidate For Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy (Eg, Allergy, Intolerance, Pregnancy, Renal Failure Due To Ace Inhibitor, Diseases Of The Aortic Or Mitral Valve, Other Medical Reasons) Or (Eg, Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8937	Clinician Did Not Prescribe Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8942	Functional Outcome Assessment Using A Standardized Tool Is Documented Within The Previous 30 Days And A Care Plan, Based On Identified Deficiencies Is Documented Within Two Days Of The Functional Outcome Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8944	Ajcc Melanoma Cancer Stage 0 Through Iic Melanoma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G8946	Minimally Invasive Biopsy Method Attempted But Not Diagnostic Of Breast Cancer (E.G., High Risk Lesion Of Breast Such As Atypical Ductal Hyperplasia, Lobular Neoplasia, Atypical Lobular Hyperplasia, Lobular Carcinoma In Situ, Atypical Columnar Hyperplasica, Flat Epithelial Atypia, Radial Scar, Complex Sclerosing Lesion, Papillary Lesion, Or Any Lesion With Spindle Cells)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8950	Elevated Or Hypertensive Blood Pressure Reading Documented, And The Indicated Follow-Up Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8952	Elevated Or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8955	Most Recent Assessment Of Adequacy Of Volume Management Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8956	Patient Receiving Maintenance Hemodialysis In An Outpatient Dialysis Facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8958	Assessment Of Adequacy Of Volume Management Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8961	Cardiac Stress Imaging Test Primarily Performed On Low-Risk Surgery Patient For Preoperative Evaluation Within 30 Days Preceding This Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8962	Cardiac Stress Imaging Test Performed On Patient For Any Reason Including Those Who Did Not Have Low Risk Surgery Or Test That Was Performed More Than 30 Days Preceding Low Risk Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8965	Cardiac Stress Imaging Test Primarily Performed On Low Chd Risk Patient For Initial Detection And Risk Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8966	Cardiac Stress Imaging Test Performed On Symptomatic Or Higher Than Low Chd Risk Patient Or For Any Reason Other Than Initial Detection And Risk Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8967	Fda Approved Oral Anticoagulant Is Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8968	Documentation Of Medical Reason(S) For Not Prescribing An Fda-Approved Anticoagulant (E.G., Present Or Planned Atrial Appendage Occlusion Or Ligation Or Patient Being Currently Enrolled In A Clinical Trial Related To Af/Atrial Flutter Treatment)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8969	Documentation Of Patient Reason(S) For Not Prescribing An Oral Anticoagulant That Is Fda Approved For The Prevention Of Thromboembolism (E.G., Patient Preference For Not Receiving Anticoagulation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G8970	No Risk Factors Or One Moderate Risk Factor For Thromboembolism	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9013	Esrd Demo Basic Bundle Level I	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9014	Esrd Demo Expanded Bundle Including Venous Access And Related Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9016	Smoking Cessation Counseling, Individual, In The Absence Of Or In Addition To Any Other Evaluation And Management Service, Per Session (6-10 Minutes) [Demo Project Code Only]	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9050	Oncology; Primary Focus Of Visit; Work-Up, Evaluation, Or Staging At The Time Of Cancer Diagnosis Or Recurrence (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9051	Oncology; Primary Focus Of Visit; Treatment Decision-Making After Disease Is Staged Or Restaged, Discussion Of Treatment Options, Supervising/Coordinating Active Cancer Directed Therapy Or Managing Consequences Of Cancer Directed Therapy (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9052	Oncology; Primary Focus Of Visit; Surveillance For Disease Recurrence For Patient Who Has Completed Definitive Cancer-Directed Therapy And Currently Lacks Evidence Of Recurrent Disease; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9053	Oncology; Primary Focus Of Visit; Expectant Management Of Patient With Evidence Of Cancer For Whom No Cancer Directed Therapy Is Being Administered Or Arranged At Present; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9054	Oncology; Primary Focus Of Visit; Supervising, Coordinating Or Managing Care Of Patient With Terminal Cancer Or For Whom Other Medical Illness Prevents Further Cancer Treatment; Includes Symptom Management, End-Of-Life Care Planning, Management Of Palliative Therapies (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9055	Oncology; Primary Focus Of Visit; Other, Unspecified Service Not Otherwise Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9056	Oncology; Practice Guidelines; Management Adheres To Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9057	Oncology; Practice Guidelines; Management Differs From Guidelines As A Result Of Patient Enrollment In An Institutional Review Board Approved Clinical Trial (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
G9058	Oncology; Practice Guidelines; Management Differs From Guidelines Because The Treating Physician Disagrees With Guideline Recommendations (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9059	Oncology; Practice Guidelines; Management Differs From Guidelines Because The Patient, After Being Offered Treatment Consistent With Guidelines, Has Opted For Alternative Treatment Or Management, Including No Treatment (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9060	Oncology; Practice Guidelines; Management Differs From Guidelines For Reason(S) Associated With Patient Comorbid Illness Or Performance Status Not Factored Into Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9061	Oncology; Practice Guidelines; Patient'S Condition Not Addressed By Available Guidelines (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9062	Oncology; Practice Guidelines; Management Differs From Guidelines For Other Reason(S) Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9063	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage I (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9064	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Ii (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9065	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Iii A (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9066	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Stage Iii B- Iv At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9067	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999
G9069	Oncology; Disease Status; Small Cell Lung Cancer, Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extensive Stage At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9070	Oncology; Disease Status; Small Cell Lung Cancer, Limited To Small Cell And Combined Small Cell/Non-Small; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9071	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3, N1, M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9072	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I, Or Stage Iia-Iib; Or T3, N1, M0; And Er And Pr Negative; With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9073	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3, N1, M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9074	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3, N1, M0; And Er And Pr Negative; With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9075	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9077	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma As Predominant Cell Type; T1-T2C And Gleason 2-7 And Psa < Or Equal To 20 At Diagnosis With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999
G9079	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma As Predominant Cell Type; T3B-T4, Any N; Any T, N1 At Diagnosis With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9080	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma; After Initial Treatment With Rising Psa Or Failure Of Psa Decline (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9083	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9084	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3, N0, M0 With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9085	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4, N0, M0 With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9086	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-4, N1-2, M0 With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9087	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive With Current Clinical, Radiologic, Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9088	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive Without Current Clinical, Radiologic, Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9089	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9090	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-2, N0, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9091	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T3, N0, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9092	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3, N1-2, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9093	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4, Any N, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9094	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9095	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9096	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-T3, N0-N1 Or Nx (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9097	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4, Any N, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9098	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9099	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9100	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As Predominant Cell Type; Post R0 Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Recurrence, Progression, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9101	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As Predominant Cell Type; Post R1 Or R2 Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Progression, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9102	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic M0, Unresectable With No Evidence Of Disease Progression, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9103	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9104	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9106	Oncology; Disease Status; Pancreatic Cancer, Limited To Adenocarcinoma; Post R1 Or R2 Resection With No Evidence Of Disease Progression, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9107	Oncology; Disease Status; Pancreatic Cancer, Limited To Adenocarcinoma; Unresectable At Diagnosis, M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9108	Oncology; Disease Status; Pancreatic Cancer, Limited To Adenocarcinoma; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999

G9110	Oncology; Disease Status; Head And Neck Cancer, Limited To Cancers Of Oral Cavity, Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Initially Established As T3-4 And/Or N1-3, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9111	Oncology; Disease Status; Head And Neck Cancer, Limited To Cancers Of Oral Cavity, Pharynx And Larynx With Squamous Cell As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9112	Oncology; Disease Status; Head And Neck Cancer, Limited To Cancers Of Oral Cavity, Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9113	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 1) Without Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9114	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 2-3); Or Stage Ic (All Grades); Or Stage Ii; Without Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9115	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Pathologic Stage Iii-Iv; Without Evidence Of Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9116	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Evidence Of Disease Progression, Or Recurrence, And/Or Platinum Resistance (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9117	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9123	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Chronic Phase Not In Hematologic, Cytogenetic, Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999
G9125	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Blast Phase Not In Hematologic, Cytogenetic, Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9126	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; In Hematologic, Cytogenetic, Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999
G9129	Oncology; Disease Status; Limited To Multiple Myeloma, Systemic Disease; Stage Ii Or Higher (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9130	Oncology; Disease Status; Limited To Multiple Myeloma, Systemic Disease; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9131	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9132	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma; Hormone-Refractory/Androgen-Independent (E.G., Rising Psa On Anti-Androgen Therapy Or Post-Orchiectomy); Clinical Metastases (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9133	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma; Hormone-Responsive; Clinical Metastases Or M1 At Diagnosis (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9134	Oncology; Disease Status; Non-Hodgkin?S Lymphoma, Any Cellular Classification; Stage I, Ii At Diagnosis, Not Relapsed, Not Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9135	Oncology; Disease Status; Non-Hodgkin?S Lymphoma, Any Cellular Classification; Stage Iii, Iv, Not Relapsed, Not Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
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.	5/16/2016	12/31/2999
G9137	Oncology; Disease Status; Non-Hodgkin?S Lymphoma, Any Cellular Classification; Relapsed/Refractory (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9138	Oncology; Disease Status; Non-Hodgkin?S Lymphoma, Any Cellular Classification; Diagnostic Evaluation, Stage Not Determined, Evaluation Of Possible Relapse Or Non-Response To Therapy, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9139	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Extent Of Disease Unknown, Staging In Progress, Not Listed (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9140	Frontier Extended Stay Clinic Demonstration; For A Patient Stay In A Clinic Approved For The Cms Demonstration Project; The Following Measures Should Be Present: The Stay Must Be Equal To Or Greater Than 4 Hours; Weather Or Other Conditions Must Prevent Transfer Or The Case Falls Into A Category Of Monitoring And Observation Cases That Are Permitted By The Rules Of The Demonstration; There Is A Maximum Frontier Extended Stay Clinic (Fesc) Visit Of 48 Hours, Except In The Case When Weather Or Other Conditions Prevent Transfer; Payment Is Made On Each Period Up To 4 Hours, After The First 4 Hours	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous, By Any Means, Guided By The Results Of Measurements For:Respiratory Quotient; And/Or, Urine Urea Nitrogen (Uun); And/Or, Arterial, Venous Or Capillary Glucose; And/Or Potassium Concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
G9148	National Committee For Quality Assurance - Level I Medical Home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9149	National Committee For Quality Assurance - Level Ii Medical Home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9150	National Committee For Quality Assurance - Level Iii Medical Home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9151	Multi-Payer Advanced Primary Care Practice Demonstration State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9152	Multi-Payer Advanced Primary Care Practice Demonstration Community	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9153	Multi-Payer Advanced Primary Care Practice Demonstration Physician	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9187	Bundled Payments For Care Improvement Initiative Home Visit For Patient Assessment Performed By A Qualified Health Care Professional For Individuals Not Considered Homebound Including, But Not Limited To, Assessment Of Safety, Falls, Clinical Status, Fluid Status, Medication Reconciliation/Management, Patient Compliance With Orders/Plan Of Care, Performance Of Activities Of Daily Living, Appropriateness Of Care Setting. (For Use Only In The Medicare-Approved Bundled Payments For Care Improvement Initiative.) 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.	10/1/2013	12/31/2999
G9188	Beta-Blocker Therapy Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9189	Beta-Blocker Therapy Prescribed Or Currently Being Taken	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9190	Documentation Of Medical Reason(S) For Not Prescribing Beta-Blocker Therapy (Eg, Allergy, Intolerance, Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9191	Documentation Of Patient Reason(S) For Not Prescribing Beta-Blocker Therapy (Eg, Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9212	Dsm-Ivtm Criteria For Major Depressive Disorder Documented At The Initial Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9213	Dsm-Iv-Tr Criteria For Major Depressive Disorder Not Documented At The Initial Evaluation, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

G9223	Pneumocystis Jiroveci Pneumonia Prophylaxis Prescribed Within 3 Months Of Low Cd4+ Cell Count Below 500 Cells/Mm3 Or A Cd4 Percentage Below 15%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9225	Foot Exam Was Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9226	Foot Examination Performed (Includes Examination Through Visual Inspection, Sensory Exam With 10-G Monofilament Plus Testing Any One Of The Following: Vibration Using 128-Hz Tuning Fork, Pinprick Sensation, Ankle Reflexes, Or Vibration Perception Threshold, And Pulse Exam; Report When All Of The 3 Components Are Completed)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9227	Functional Outcome Assessment Documented, Care Plan Not Documented, Documentation The Patient Is Not Eligible For A Care Plan At The Time Of The Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9228	Chlamydia, Gonorrhea And Syphilis Screening Results Documented (Report When Results Are Present For All Of The 3 Screenings)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9230	Chlamydia, Gonorrhea, And Syphilis Not Screened, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9231	Documentation Of End Stage Renal Disease (Esrd), Dialysis, Renal Transplant Before Or During The Measurement Period Or Pregnancy During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9242	Documentation Of Viral Load Equal To Or Greater Than 200 Copies/Ml Or Viral Load Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9243	Documentation Of Viral Load Less Than 200 Copies/Ml	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9246	Patient Did Not Have At Least One Medical Visit In Each 6 Month Period Of The 24 Month Measurement Period, With A Minimum Of 60 Days Between Medical Visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9247	Patient Had At Least One Medical Visit In Each 6 Month Period Of The 24 Month Measurement Period, With A Minimum Of 60 Days Between Medical Visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9254	Documentation Of Patient Discharged To Home Later Than Post-Operative Day 2 Following Cas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9255	Documentation Of Patient Discharged To Home No Later Than Post Operative Day 2 Following Cas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9273	Blood Pressure Has A Systolic Value Of < 140 And A Diastolic Value Of < 90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9274	Blood Pressure Has A Systolic Value Of =140 And A Diastolic Value Of = 90 Or Systolic Value < 140 And Diastolic Value = 90 Or Systolic Value = 140 And Diastolic Value < 90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9275	Documentation That Patient Is A Current Non-Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9276	Documentation That Patient Is A Current Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

G9277	Documentation That The Patient Is On Daily Aspirin Or Anti-Platelet Or Has Documentation Of A Valid Contraindication Or Exception To Aspirin/Anti-Platelet; Contraindications/Exceptions Include Anti-Coagulant Use, Allergy To Aspirin Or Anti-Platelets, History Of Gastrointestinal Bleed And Bleeding Disorder; Additionally, The Following Exceptions Documented By The Physician As A Reason For Not Taking Daily Aspirin Or Anti-Platelet Are Acceptable (Use Of Non-Steroidal Anti-Inflammatory Agents, Documented Risk For Drug Interaction, Uncontrolled Hypertension Defined As >180 Systolic Or >110 Diastolic Or Gastroesophageal Reflux)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9278	Documentation That The Patient Is Not On Daily Aspirin Or Anti-Platelet Regimen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9279	Pneumococcal Screening Performed And Documentation Of Vaccination Received Prior To Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9280	Pneumococcal Vaccination Not Administered Prior To Discharge, Reason Not Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9281	Screening Performed And Documentation That Vaccination Not Indicated/Patient Refusal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9282	Documentation Of Medical Reason(S) For Not Reporting The Histological Type Or Nsclc-Nos Classification With An Explanation (E.G., Biopsy Taken For Other Purposes In A Patient With A History Of Non-Small Cell Lung Cancer Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9283	Non Small Cell Lung Cancer Biopsy And Cytology Specimen Report Documents Classification Into Specific Histologic Type Or Classified As Nsclc-Nos With An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9284	Non Small Cell Lung Cancer Biopsy And Cytology Specimen Report Does Not Document Classification Into Specific Histologic Type Or Classified As Nsclc-Nos With An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9285	Specimen Site Other Than Anatomic Location Of Lung Or Is Not Classified As Non Small Cell Lung Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9286	Antibiotic Regimen Prescribed Within10 Days After Onset Of Symptoms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9287	Antibiotic Regimen Not Prescribed Within 10 Days After Onset Of Symptoms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9288	Documentation Of Medical Reason(S) For Not Reporting The Histological Type Or Nsclc-Nos Classification With An Explanation (E.G., A Solitary Fibrous Tumor In A Person With A History Of Non-Small Cell Carcinoma Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9289	Non Small Cell Lung Cancer Biopsy And Cytology Specimen Report Documents Classification Into Specific Histologic Type Or Classified As Nsclc-Nos With An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9290	Non Small Cell Lung Cancer Biopsy And Cytology Specimen Report Does Not Document Classification Into Specific Histologic Type Or Classified As Nsclc-Nos With An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9291	Specimen Site Other Than Anatomic Location Of Lung, Is Not Classified As Non Small Cell Lung Cancer Or Classified As Nsclc-Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9292	Documentation Of Medical Reason(S) For Not Reporting Pt Category And A Statement On Thickness And Ulceration And For Pt1, Mitotic Rate (E.G., Negative Skin Biopsies In A Patient With A History Of Melanoma Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

G9293	Pathology Report Does Not Include The Pt Category And A Statement On Thickness And Ulceration And For Pt1, Mitotic Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9294	Pathology Report Includes The Pt Category And A Statement On Thickness And Ulceration And For Pt1, Mitotic Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9295	Specimen Site Other Than Anatomic Cutaneous Location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9296	Patients With Documented Shared Decision-Making Including Discussion Of Conservative (Non-Surgical) Therapy (E.G., Nsaids, Analgesics, Weight Loss, Exercise, Injections) Prior To The Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9297	Shared Decision-Making Including Discussion Of Conservative (Non-Surgical) Therapy (E.G., Nsaids, Analgesics, Weight Loss, Exercise, Injections) Prior To The Procedure, Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9298	Patients Who Are Evaluated For Venous Thromboembolic And Cardiovascular Risk Factors Within 30 Days Prior To The Procedure (E.G. History Of Dvt, Pe, Mi, Arrhythmia And Stroke)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9299	Patients Who Are Not Evaluated For Venous Thromboembolic And Cardiovascular Risk Factors Within 30 Days Prior To The Procedure (E.G., History Of Dvt, Pe, Mi, Arrhythmia And Stroke, Reason Not Given)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9305	Intervention For Presence Of Leak Of Endoluminal Contents Through An Anastomosis Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9306	Intervention For Presence Of Leak Of Endoluminal Contents Through An Anastomosis Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9307	No Return To The Operating Room For A Surgical Procedure, For Complications Of The Principal Operative Procedure, Within 30 Days Of The Principal Operative Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9308	Unplanned Return To The Operating Room For A Surgical Procedure, For Complications Of The Principal Operative Procedure, Within 30 Days Of The Principal Operative Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9309	No Unplanned Hospital Readmission Within 30 Days Of Principal Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9310	Unplanned Hospital Readmission Within 30 Days Of Principal Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9311	No Surgical Site Infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9312	Surgical Site Infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9313	Amoxicillin, With Or Without Clavulanate, Not Prescribed As First Line Antibiotic At The Time Of Diagnosis For Documented Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9314	Amoxicillin, With Or Without Clavulanate, Not Prescribed As First Line Antibiotic At The Time Of Diagnosis, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9315	Amoxicillin, With Or Without Clavulanate, Prescribed As A First Line Antibiotic At The Time Of Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9316	Documentation Of Patient-Specific Risk Assessment With A Risk Calculator Based On Multi-Institutional Clinical Data, The Specific Risk Calculator Used, And Communication Of Risk Assessment From Risk Calculator With The Patient Or Family	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

G9317	Documentation Of Patient-Specific Risk Assessment With A Risk Calculator Based On Multi-Institutional Clinical Data, The Specific Risk Calculator Used, And Communication Of Risk Assessment From Risk Calculator With The Patient Or Family Not Completed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9318	Imaging Study Named According To Standardized Nomenclature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9319	Imaging Study Not Named According To Standardized Nomenclature, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9321	Count Of Previous Ct (Any Type Of Ct) And Cardiac Nuclear Medicine (Myocardial Perfusion) Studies Documented In The 12-Month Period Prior To The Current Study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9322	Count Of Previous Ct And Cardiac Nuclear Medicine (Myocardial Perfusion) Studies Not Documented In The 12-Month Period Prior To The Current Study, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9341	Search Conducted For Prior Patient Ct Studies Completed At Non-Affiliated External Healthcare Facilities Or Entities Within The Past 12-Months And Are Available Through A Secure, Authorized, Media-Free, Shared Archive Prior To An Imaging Study Being Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9342	Search Not Conducted Prior To An Imaging Study Being Performed For Prior Patient Ct Studies Completed At Non-Affiliated External Healthcare Facilities Or Entities Within The Past 12-Months And Are Available Through A Secure, Authorized, Media-Free, Shared Archive, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9344	Due To System Reasons Search Not Conducted For Dicom Format Images For Prior Patient Ct Imaging Studies Completed At Non-Affiliated External Healthcare Facilities Or Entities Within The Past 12 Months That Are Available Through A Secure, Authorized, Media-Free, Shared Archive (E.G., Non-Affiliated External Healthcare Facilities Or Entities Does Not Have Archival Abilities Through A Shared Archival System)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9345	Follow-Up Recommendations Documented According To Recommended Guidelines For Incidentally Detected Pulmonary Nodules (E.G., Follow-Up Ct Imaging Studies Needed Or That No Follow-Up Is Needed) Based At A Minimum On Nodule Size And Patient Risk Factors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9347	Follow-Up Recommendations Not Documented According To Recommended Guidelines For Incidentally Detected Pulmonary Nodules, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9351	More Than One Ct Scan Of The Paranasal Sinuses Ordered Or Received Within 90 Days After Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9352	More Than One Ct Scan Of The Paranasal Sinuses Ordered Or Received Within 90 Days After The Date Of Diagnosis, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9353	More Than One Ct Scan Of The Paranasal Sinuses Ordered Or Received Within 90 Days After The Date Of Diagnosis For Documented Reasons (Eg, Patients With Complications, Second Ct Obtained Prior To Surgery, Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9354	One Ct Scan Or No Ct Scan Of The Paranasal Sinuses Ordered Within 90 Days After The Date Of Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

G9355	Elective Delivery (Without Medical Indication) By Cesarean Birth Or Induction Of Labor Not Performed (<39 Weeks Of Gestation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9356	Elective Delivery (Without Medical Indication) By Cesarean Birth Or Induction Of Labor Performed (<39 Weeks Of Gestation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9357	Post-Partum Screenings, Evaluations And Education Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9358	Post-Partum Screenings, Evaluations And Education Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
G9361	Medical Indication For Delivery By Cesarean Birth Or Induction Of Labor (<39 Weeks Of Gestation) [Documentation Of Reason(S) For Elective Delivery (E.G., Hemorrhage And Placental Complications, Hypertension, Preeclampsia And Eclampsia, Rupture Of Membranes (Premature Or Prolonged), Maternal Conditions Complicating Pregnancy/Delivery, Fetal Conditions Complicating Pregnancy/Delivery, Late Pregnancy, Prior Uterine Surgery, Or Participation In Clinical Trial)]	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9364	Sinusitis Caused By, Or Presumed To Be Caused By, Bacterial Infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9367	At Least Two Orders For High-Risk Medications From The Same Drug Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9368	At Least Two Orders For High-Risk Medications From The Same Drug Class Not Ordered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9380	Patient Offered Assistance With End Of Life Issues Or Existing End Of Life Plan Was Reviewed Or Updated During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9382	Patient Not Offered Assistance With End Of Life Issues Or Existing End Of Life Plan Was Not Reviewed Or Updated During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9383	Patient Received Screening For Hcv Infection Within The 12 Month Reporting Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9384	Documentation Of Medical Reason(S) For Not Receiving Annual Screening For Hcv Infection (E.G., Decompensated Cirrhosis Indicating Advanced Disease [I.E., Ascites, Esophageal Variceal Bleeding, Hepatic Encephalopathy], Hepatocellular Carcinoma, Waitlist For Organ Transplant, Limited Life Expectancy, Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9385	Documentation Of Patient Reason(S) For Not Receiving Annual Screening For Hcv Infection (E.G., Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9386	Screening For Hcv Infection Not Received Within The 12 Month Reporting Period, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9393	Patient With An Initial Phq-9 Score Greater Than Nine Who Achieves Remission At Twelve Months As Demonstrated By A Twelve Month (+/- 30 Days) Phq-9 Score Of Less Than Five	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9394	Patient Who Had A Diagnosis Of Bipolar Disorder Or Personality Disorder, Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The Measurement Or Assessment Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9395	Patient With An Initial Phq-9 Score Greater Than Nine Who Did Not Achieve Remission At Twelve Months As Demonstrated By A Twelve Month (+/- 30 Days) Phq-9 Score Greater Than Or Equal To Five	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9396	Patient With An Initial Phq-9 Score Greater Than Nine Who Was Not Assessed For Remission At Twelve Months (+/- 30 Days)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9402	Patient Received Follow-Up Within 30 Days After Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9403	Clinician Documented Reason Patient Was Not Able To Complete 30 Day Follow-Up From Acute Inpatient Setting Discharge (E.G., Patient Death Prior To Follow-Up Visit, Patient Non-Compliant For Visit Follow-Up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9404	Patient Did Not Receive Follow-Up Within 30 Days After Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9405	Patient Received Follow-Up Within 7 Days After Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9406	Clinician Documented Reason Patient Was Not Able To Complete 7 Day Follow-Up From Acute Inpatient Setting Discharge (I.E Patient Death Prior To Follow-Up Visit, Patient Non-Compliance For Visit Follow-Up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9407	Patient Did Not Receive Follow-Up Within 7 Days After Discharge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9408	Patients With Cardiac Tamponade And/Or Pericardiocentesis Occurring Within 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9409	Patients Without Cardiac Tamponade And/Or Pericardiocentesis Occurring Within 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9410	Patient Admitted Within 180 Days, Status Post Cied Implantation, Replacement, Or Revision With An Infection Requiring Device Removal Or Surgical Revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9411	Patient Not Admitted Within 180 Days, Status Post Cied Implantation, Replacement, Or Revision With An Infection Requiring Device Removal Or Surgical Revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9412	Patient Admitted Within 180 Days, Status Post Cied Implantation, Replacement, Or Revision With An Infection Requiring Device Removal Or Surgical Revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9413	Patient Not Admitted Within 180 Days, Status Post Cied Implantation, Replacement, Or Revision With An Infection Requiring Device Removal Or Surgical Revision	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9414	Patient Had One Dose Of Meningococcal Vaccine (Serogroups A, C, W, Y) On Or Between The Patient'S 11Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9415	Patient Did Not Have One Dose Of Meningococcal Vaccine (Serogroups A, C, W, Y) On Or Between The Patient'S 11Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9416	Patient Had One Tetanus, Diphtheria Toxoids And Acellular Pertussis Vaccine (Tdap) On Or Between The Patient'S 10Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9417	Patient Did Not Have One Tetanus, Diphtheria Toxoids And Acellular Pertussis Vaccine (Tdap) On Or Between The Patient'S 10Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9418	Primary Non-Small Cell Lung Cancer Lung Biopsy And Cytology Specimen Report Documents Classification Into Specific Histologic Type Following Iaslc Guidance Or Classified As Nsclc-Nos With An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9419	Documentation Of Medical Reason(S) For Not Including The Histological Type Or Nsclc-Nos Classification With An Explanation (E.G. Specimen Insufficient Or Non-Diagnostic, Specimen Does Not Contain Cancer, Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9420	Specimen Site Other Than Anatomic Location Of Lung Or Is Not Classified As Primary Non-Small Cell Lung Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9421	Primary Non-Small Cell Lung Cancer Lung Biopsy And Cytology Specimen Report Does Not Document Classification Into Specific Histologic Type Or Histologic Type Does Not Follow Iaslc Guidance Or Is Classified As Nsclc-Nos But Without An Explanation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9422	Primary Lung Carcinoma Resection Report Documents Pt Category, Pn Category And For Non-Small Cell Lung Cancer, Histologic Type (E.G., Squamous Cell Carcinoma, Adenocarcinoma And Not Nsclc-Nos)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9423	Documentation Of Medical Reason(S) For Not Reporting The Histological Type Or Nsclc-Nos Classification With An Explanation (E.G., A Solitary Fibrous Tumor In A Person With A History Of Non-Small Cell Carcinoma Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9424	Specimen Site Other Than Anatomic Location Of Lung, Is Not Classified As Non-Small Cell Lung Cancer Or Classified As Nsclc-Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9425	Primary Lung Carcinoma Resection Report Does Not Document Pt Category, Pn Category And For Non-Small Cell Lung Cancer, Histologic Type (E.G., Squamous Cell Carcinoma, Adenocarcinoma)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9426	Improvement In Median Time From Ed Arrival To Initial Ed Oral Or Parenteral Pain Medication Administration Performed For Ed Admitted Patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9427	Improvement In Median Time From Ed Arrival To Initial Ed Oral Or Parenteral Pain Medication Administration Not Performed For Ed Admitted Patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9428	Pathology Report Includes The Pt Category, Thickness, Ulceration And Mitotic Rate, Peripheral And Deep Margin Status And Presence Or Absence Of Microsatellitosis For Invasive Tumors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9429	Documentation Of Medical Reason(S) For Not Including Pt Category, Thickness, Ulceration And Mitotic Rate, Peripheral And Deep Margin Status And Presence Or Absence Of Microsatellitosis For Invasive Tumors (E.G., Negative Skin Biopsies, Insufficient Tissue, Or Other Documented Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9430	Specimen Site Other Than Anatomic Cutaneous Location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9431	Pathology Report Does Not Include The Pt Category, Thickness, Ulceration And Mitotic Rate, Peripheral And Deep Margin Status And Presence Or Absence Of Microsatellitosis For Invasive Tumors	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9432	Asthma Well-Controlled Based On The Act, C-Act, Acq, Or Ataq Score And Results Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9434	Asthma Not Well-Controlled Based On The Act, C-Act, Acq, Or Ataq Score, Or Specified Asthma Control Tool Not Used, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9455	Patient Underwent Abdominal Imaging With Ultrasound, Contrast Enhanced Ct Or Contrast Mri For Hcc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999

G9456	Documentation Of Medical Or Patient Reason(S) For Not Ordering Or Performing Screening For Hcc. Medical Reason: Comorbid Medical Conditions With Expected Survival < 5 Years, Hepatic Decompensation And Not A Candidate For Liver Transplantation, Or Other Medical Reasons; Patient Reasons: Patient Declined Or Other Patient Reasons (E.G., Cost Of Tests, Time Related To Accessing Testing Equipment)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9457	Patient Did Not Undergo Abdominal Imaging And Did Not Have A Documented Reason For Not Undergoing Abdominal Imaging In The Submission Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9458	Patient Documented As Tobacco User And Received Tobacco Cessation Intervention (Must Include At Least One Of The Following: Advice Given To Quit Smoking Or Tobacco Use, Counseling On The Benefits Of Quitting Smoking Or Tobacco Use, Assistance With Or Referral To External Smoking Or Tobacco Cessation Support Programs, Or Current Enrollment In Smoking Or Tobacco Use Cessation Program) If Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9459	Currently A Tobacco Non-User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9460	Tobacco Assessment Or Tobacco Cessation Intervention Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9468	Patient Not Receiving Corticosteroids Greater Than Or Equal To 10 Mg/Day Of Prednisone Equivalents For 60 Or Greater Consecutive Days Or A Single Prescription Equating To 600Mg Prednisone Or Greater For All Fills	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9470	Patients Not Receiving Corticosteroids Greater Than Or Equal To 10 Mg/Day Of Prednisone Equivalents For 60 Or Greater Consecutive Days Or A Single Prescription Equating To 600Mg Prednisone Or Greater For All Fills	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9471	Within The Past 2 Years, Central Dual-Energy X-Ray Absorptiometry (Dxa) Not Ordered Or Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
G9473	Services Performed By Chaplain In The Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G9474	Services Performed By Dietary Counselor In The Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G9475	Services Performed By Other Counselor In The Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G9476	Services Performed By Volunteer In The Hospice Setting, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9477	Services Performed By Care Coordinator In The Hospice Setting, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9478	Services Performed By Other Qualified Therapist In The Hospice Setting, Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
G9479	Services Performed By Qualified Pharmacist In The Hospice Setting, Each 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9480	Admission To Medicare Care Choice Model Program (Mccm)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9481	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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 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.	4/1/2016	12/31/2999
G9482	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9483	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999

G9484	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9485	Remote In-Home Visit For The Evaluation And Management Of A New Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9486	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999

G9487	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9488	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9489	Remote In-Home Visit For The Evaluation And Management Of An Established Patient For Use Only In A Medicare-Approved Cms Innovation Center Demonstration Project, 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.	4/1/2016	12/31/2999
G9490	Cms Innovation Center Models, 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 In Medicare-Approved Cms Innovation Center Models); 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.	4/1/2016	12/31/2999

G9497	Received Instruction From The Anesthesiologist Or Proxy Prior To The Day Of Surgery To Abstain From Smoking On The Day Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9498	Antibiotic Regimen Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9500	Radiation Exposure Indices Documented In Final Report For Procedure Using Fluoroscopy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9501	Radiation Exposure Indices Not Documented In Final Report For Procedure Using Fluoroscopy, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9502	Documentation Of Medical Reason For Not Performing Foot Exam (I.E., Patients Who Have Had Either A Bilateral Amputation Above Or Below The Knee, Or Both A Left And Right Amputation Above Or Below The Knee Before Or During The Measurement Period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9504	Documented Reason For Not Assessing Hepatitis B Virus (Hbv) Status (E.G., Patient Not Initiating Anti-Tnf Therapy, Patient Declined) Prior To Initiating Anti-Tnf Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9505	Antibiotic Regimen Prescribed Within 10 Days After Onset Of Symptoms For Documented Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9507	Documentation That The Patient Is On A Statin Medication Or Has Documentation Of A Valid Contraindication Or Exception To Statin Medications; Contraindications/Exceptions That Can Be Defined By Diagnosis Codes Include Pregnancy During The Measurement Period, Active Liver Disease, Rhabdomyolysis, End Stage Renal Disease On Dialysis And Heart Failure; Provider Documented Contraindications/Exceptions Include Breastfeeding During The Measurement Period, Woman Of Child-Bearing Age Not Actively Taking Birth Control, Allergy To Statin, Drug Interaction (Hiv Protease Inhibitors, Nefazodone, Cyclosporine, Gemfibrozil, And Danazol) And Intolerance (With Supporting Documentation Of Trying A Statin At Least Once Within The Last 5 Years Or Diagnosis Codes For Myostitis Or Toxic Myopathy Related To Drugs)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9508	Documentation That The Patient Is Not On A Statin Medication	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9509	Adult Patients 18 Years Of Age Or Older With Major Depression Or Dysthymia Who Reached Remission At Twelve Months As Demonstrated By A Twelve Month (+/-60 Days) Phq-9 Or Phq-9M Score Of Less Than 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9510	Adult Patients 18 Years Of Age Or Older With Major Depression Or Dysthymia Who Did Not Reach Remission At Twelve Months As Demonstrated By A Twelve Month (+/-60 Days) Phq-9 Or Phq-9M Score Of Less Than 5. Either Phq- 9 Or Phq-9M Score Was Not Assessed Or Is Greater Than Or Equal To 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9511	Index Event Date Phq-9 Or Phq-9M Score Greater Than 9 Documented During The Twelve Month Denominator Identification Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9512	Individual Had A Pdc Of 0.8 Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9513	Individual Did Not Have A Pdc Of 0.8 Or Greater	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9514	Patient Required A Return To The Operating Room Within 90 Days Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9515	Patient Did Not Require A Return To The Operating Room Within 90 Days Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9516	Patient Achieved An Improvement In Visual Acuity, From Their Preoperative Level, Within 90 Days Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9517	Patient Did Not Achieve An Improvement In Visual Acuity, From Their Preoperative Level, Within 90 Days Of Surgery, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9518	Documentation Of Active Injection Drug Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9519	Patient Achieves Final Refraction (Spherical Equivalent) +/- 1.0 Diopters Of Their Planned Refraction Within 90 Days Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9520	Patient Does Not Achieve Final Refraction (Spherical Equivalent) +/- 1.0 Diopters Of Their Planned Refraction Within 90 Days Of Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9521	Total Number Of Emergency Department Visits And Inpatient Hospitalizations Less Than Two In The Past 12 Months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9522	Total Number Of Emergency Department Visits And Inpatient Hospitalizations Equal To Or Greater Than Two In The Past 12 Months Or Patient Not Screened, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9529	Patient With Minor Blunt Head Trauma Had An Appropriate Indication(S) For A Head Ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9530	Patient Presented With A Minor Blunt Head Trauma And Had A Head Ct Ordered For Trauma By An Emergency Care Provider	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9531	Patient Has Documentation Of Ventricular Shunt, Brain Tumor, Multisystem Trauma, Or Is Currently Taking An Antiplatelet Medication Including: Abciximab, Anagrelide, Cangrelor, Cilostazol, Clopidogrel, Dipyridamole, Eptifibatide, Prasugrel, Ticlopidine, Ticagrelor, Tirofiban, Or Vorapaxar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9533	Patient With Minor Blunt Head Trauma Did Not Have An Appropriate Indication(S) For A Head Ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9537	Imaging Needed As Part Of A Clinical Trial; Or Other Clinician Ordered The Study	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9539	Intent For Potential Removal At Time Of Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9540	Patient Alive 3 Months Post Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9541	Filter Removed Within 3 Months Of Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9542	Documented Re-Assessment For The Appropriateness Of Filter Removal Within 3 Months Of Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9543	Documentation Of At Least Two Attempts To Reach The Patient To Arrange A Clinical Re-Assessment For The Appropriateness Of Filter Removal Within 3 Months Of Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9544	Patients That Do Not Have The Filter Removed, Documented Re-Assessment For The Appropriateness Of Filter Removal, Or Documentation Of At Least Two Attempts To Reach The Patient To Arrange A Clinical Re-Assessment For The Appropriateness Of Filter Removal Within 3 Months Of Placement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9547	Cystic Renal Lesion That Is Simple Appearing (Bosniak I Or Ii) , Or Adrenal Lesion Less Than Or Equal To 1.0 Cm Or Adrenal Lesion Greater Than 1.0 Cm But Less Than Or Equal To 4.0 Cm Classified As Likely Benign By Unenhanced Ct Or Washout Protocol Ct, Or Mri With In- And Opposed-Phase Sequences Or Other Equivalent Institutional Imaging Protocols	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9548	Final Reports For Imaging Studies Stating No Follow-Up Imaging Is Recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9549	Documentation Of Medical Reason(S) That Follow-Up Imaging Is Indicated (E.G., Patient Has Lymphadenopathy, Signs Of Metastasis Or An Active Diagnosis Or History Of Cancer, And Other Medical Reason(S))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9550	Final Reports For Imaging Studies With Follow-Up Imaging Recommended, Or Final Reports That Do Not Include A Specific Recommendation Of No Follow-Up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9551	Final Reports For Imaging Studies Without An Incidentally Found Lesion Noted	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9552	Incidental Thyroid Nodule < 1.0 Cm Noted In Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9553	Prior Thyroid Disease Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9554	Final Reports For Ct, Cta, Mri Or Mra Of The Chest Or Neck With Follow-Up Imaging Recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9555	Documentation Of Medical Reason(S) For Recommending Follow Up Imaging (E.G., Patient Has Multiple Endocrine Neoplasia, Patient Has Cervical Lymphadenopathy, Other Medical Reason(S))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9556	Final Reports For Ct, Cta, Mri Or Mra Of The Chest Or Neck With Follow-Up Imaging Not Recommended	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9557	Final Reports For Ct, Cta, Mri Or Mra Studies Of The Chest Or Neck Without An Incidentally Found Thyroid Nodule < 1.0 Cm Noted Or No Nodule Found	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9580	Door To Puncture Time Of 90 Minutes Or Less	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9582	Door To Puncture Time Of Greater Than 90 Minutes, No Reason Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9593	Pediatric Patient With Minor Blunt Head Trauma Classified As Low Risk According To The Pecarn Prediction Rules	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9594	Patient Presented With A Minor Blunt Head Trauma And Had A Head Ct Ordered For Trauma By An Emergency Care Provider	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9595	Patient Has Documentation Of Ventricular Shunt, Brain Tumor, Or Coagulopathy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9597	Pediatric Patient With Minor Blunt Head Trauma Not Classified As Low Risk According To The Pecarn Prediction Rules	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9598	Aortic Aneurysm 5.5 - 5.9 Cm Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9599	Aortic Aneurysm 6.0 Cm Or Greater Maximum Diameter On Centerline Formatted Ct Or Minor Diameter On Axial Formatted Ct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9603	Patient Survey Score Improved From Baseline Following Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9604	Patient Survey Results Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9605	Patient Survey Score Did Not Improve From Baseline Following Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9606	Intraoperative Cystoscopy Performed To Evaluate For Lower Tract Injury	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9607	Documented Medical Reasons For Not Performing Intraoperative Cystoscopy (E.G., Urethral Pathology Precluding Cystoscopy, Any Patient Who Has A Congenital Or Acquired Absence Of The Urethra) Or In The Case Of Patient Death	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9608	Intraoperative Cystoscopy Not Performed To Evaluate For Lower Tract Injury	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9609	Documentation Of An Order For Anti-Platelet Agents	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9610	Documentation Of Medical Reason(S) In The Patient'S Record For Not Ordering Anti-Platelet Agents	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9611	Order For Anti-Platelet Agents Was Not Documented In The Patient'S Record, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9621	Patient Identified As An Unhealthy Alcohol User When Screened For Unhealthy Alcohol Use Using A Systematic Screening Method And Received Brief Counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9622	Patient Not Identified As An Unhealthy Alcohol User When Screened For Unhealthy Alcohol Use Using A Systematic Screening Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9624	Patient Not Screened For Unhealthy Alcohol Use Using A Systematic Screening Method Or Patient Did Not Receive Brief Counseling If Identified As An Unhealthy Alcohol User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9625	Patient Sustained Bladder Injury At The Time Of Surgery Or Discovered Subsequently Up To 30 Days Post-Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9626	Documented Medical Reason For Not Reporting Bladder Injury (E.G., Gynecologic Or Other Pelvic Malignancy Documented, Concurrent Surgery Involving Bladder Pathology, Injury That Occurs During A Urinary Incontinence Procedure, Patient Death From Non-Medical Causes Not Related To Surgery, Patient Died During Procedure Without Evidence Of Bladder Injury)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9627	Patient Did Not Sustain Bladder Injury At The Time Of Surgery Nor Discovered Subsequently Up To 30 Days Post-Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9628	Patient Sustained Bowel Injury At The Time Of Surgery Or Discovered Subsequently Up To 30 Days Post-Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9629	Documented Medical Reasons For Not Reporting Bowel Injury (E.G., Gynecologic Or Other Pelvic Malignancy Documented, Planned (E.G., Not Due To An Unexpected Bowel Injury) Resection And/Or Re-Anastomosis Of Bowel, Or Patient Death From Non-Medical Causes Not Related To Surgery, Patient Died During Procedure Without Evidence Of Bowel Injury)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9630	Patient Did Not Sustain A Bowel Injury At The Time Of Surgery Nor Discovered Subsequently Up To 30 Days Post-Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9637	Final Reports Without Documentation Of One Or More Dose Reduction Techniques (E.G., Automated Exposure Control, Adjustment Of The Ma And/Or Kv According To Patient Size, Use Of Iterative Reconstruction Technique)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9638	Final Reports Without Documentation Of One Or More Dose Reduction Techniques (E.G., Automated Exposure Control, Adjustment Of The Ma And/Or Kv According To Patient Size, Use Of Iterative Reconstruction Technique)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9642	Current Smoker (E.G., Cigarette, Cigar, Pipe, E-Cigarette Or Marijuana)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9643	Elective Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9644	Patients Who Abstained From Smoking Prior To Anesthesia On The Day Of Surgery Or Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9645	Patients Who Did Not Abstain From Smoking Prior To Anesthesia On The Day Of Surgery Or Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9646	Patients With 90 Day Mrs Score Of 0 To 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9648	Patients With 90 Day Mrs Score Greater Than 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9649	Psoriasis Assessment Tool Documented Meeting Any One Of The Specified Benchmarks (E.G., (Pga; 5-Point Or 6-Point Scale), Body Surface Area (Bsa), Psoriasis Area And Severity Index (Pasi) And/Or Dermatology Life Quality Index) (Dlqi))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9651	Psoriasis Assessment Tool Documented Not Meeting Any One Of The Specified Benchmarks (E.G., (Pga; 5-Point Or 6-Point Scale), Body Surface Area (Bsa), Psoriasis Area And Severity Index (Pasi) And/Or Dermatology Life Quality Index) (Dlqi)) Or Psoriasis Assessment Tool Not Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9654	Monitored Anesthesia Care (Mac)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9655	A Transfer Of Care Protocol Or Handoff Tool/Checklist That Includes The Required Key Handoff Elements Is Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9656	Patient Transferred Directly From Anesthetizing Location To Pacu Or Other Non-Icu Location	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9658	A Transfer Of Care Protocol Or Handoff Tool/Checklist That Includes The Required Key Handoff Elements Is Not Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9659	Patients Greater Than Or Equal To 86 Years Of Age Who Underwent A Screening Colonoscopy And Did Not Have A History Of Colorectal Cancer Or Other Valid Medical Reason For The Colonoscopy, Including: Iron Deficiency Anemia, Lower Gastrointestinal Bleeding, Crohn'S Disease (I.E., Regional Enteritis), Familial Adenomatous Polyposis, Lynch Syndrome (I.E., Hereditary Non-Polyposis Colorectal Cancer), Inflammatory Bowel Disease, Ulcerative Colitis, Abnormal Finding Of Gastrointestinal Tract, Or Changes In Bowel Habits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9660	Documentation Of Medical Reason(S) For A Colonoscopy Performed On A Patient Greater Than Or Equal To 86 Years Of Age (E.G., Iron Deficiency Anemia, Lower Gastrointestinal Bleeding, Crohn'S Disease (I.E., Regional Enteritis), Familial History Of Adenomatous Polyposis, Lynch Syndrome (I.E., Hereditary Non-Polyposis Colorectal Cancer), Inflammatory Bowel Disease, Ulcerative Colitis, Abnormal Finding Of Gastrointestinal Tract, Or Changes In Bowel Habits)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999

G9661	Patients Greater Than Or Equal To 86 Years Of Age Who Received A Colonoscopy For An Assessment Of Signs/Symptoms Of Gi Tract Illness, And/Or Because The Patient Meets High Risk Criteria, And/Or To Follow-Up On Previously Diagnosed Advanced Lesions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9662	Previously Diagnosed Or Have A Diagnosis Of Clinical Ascvd, Including Ascvd Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9663	Any Ldl-C Laboratory Result >= 190 Mg/Dl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9664	Patients Who Are Currently Statin Therapy Users Or Received An Order (Prescription) For Statin Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9665	Patients Who Are Not Currently Statin Therapy Users Or Did Not Receive An Order (Prescription) For Statin Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9674	Patients With Clinical Ascvd Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9675	Patients Who Have Ever Had A Fasting Or Direct Laboratory Result Of Ldl-C = 190 Mg/Dl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9676	Patients Aged 40 To 75 Years At The Beginning Of The Measurement Period With Type 1 Or Type 2 Diabetes And With An Ldl-C Result Of 70-189 Mg/Dl Recorded As The Highest Fasting Or Direct Laboratory Test Result In The Measurement Year Or During The Two Years Prior To The Beginning Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2016	12/31/2999
G9679	Onsite Acute Care Treatment Of A Nursing Facility Resident With Pneumonia. May Only Be Billed Oncper Day Per Beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9680	Onsite Acute Care Treatment Of A Nursing Facility Resident With Chf. May Only Be Billed Once Per Day Per Beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9681	Onsite Acute Care Treatment Of A Resident With Copd Or Asthma. May Only Be Billed Once Per Day Per Beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9682	Onsite Acute Care Treatment A Nursing Facility Resident With A Skin Infection. May Only Be Billed Once Per Day Per Beneficiary	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9683	Facility Service(S) For The Onsite Acute Care Treatment Of A Nursing Facility Resident With Fluid Or Electrolyte Disorder. (May Only Be Billed Once Per Day Per Beneficiary). This Service Is For A Demonstration Project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9684	Onsite Acute Care Treatment Of A Nursing Facility Resident For A Uti. May Only Be Billed Once Per Day Per Beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9685	Physician Service Or Other Qualified Health Care Professional For The Evaluation And Management Of A Beneficiary'S Acute Change In Condition In A Nursing Facility. This Service Is For A Demonstration Project	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2016	12/31/2999
G9687	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9688	Patients Using Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9689	Patient Admitted For Performance Of Elective Carotid Intervention	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9690	Patient Receiving Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9691	Patient Had Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9692	Hospice Services Received By Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9693	Patient Use Of Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9694	Hospice Services Utilized By Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9695	Long-Acting Inhaled Bronchodilator Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9696	Documentation Of Medical Reason(S) For Not Prescribing A Long-Acting Inhaled Bronchodilator (E.G., Patient Intolerance Or History Of Side Effects)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9698	Documentation Of System Reason(S) For Not Prescribing A Long-Acting Inhaled Bronchodilator (E.G., Cost Of Treatment Or Lack Of Insurance)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9699	Long-Acting Inhaled Bronchodilator Not Prescribed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9700	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9702	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9703	Episodes Where The Patient Is Taking Antibiotics (Table 1) In The 30 Days Prior To The Episode Date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9704	Ajcc Breast Cancer Stage I: T1 Mic Or T1A Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9705	Ajcc Breast Cancer Stage I: T1B (Tumor > 0.5 Cm But <= 1 Cm In Greatest Dimension) Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9706	Low (Or Very Low) Risk Of Recurrence, Prostate Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9707	Patient Received Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9708	Women Who Had A Bilateral Mastectomy Or Who Have A History Of A Bilateral Mastectomy Or For Whom There Is Evidence Of A Right And A Left Unilateral Mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9709	Hospice Services Used By Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9710	Patient Was Provided Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9711	Patients With A Diagnosis Or Past History Of Total Colectomy Or Colorectal Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9712	Documentation Of Medical Reason(S) For Prescribing Or Dispensing Antibiotic (E.G., Intestinal Infection, Pertussis, Bacterial Infection, Lyme Disease, Otitis Media, Acute Sinusitis, Acute Pharyngitis, Acute Tonsillitis, Chronic Sinusitis, Infection Of The Pharynx/Larynx/Tonsils/Adenoids, Prostatitis, Cellulitis/ Mastoiditis/Bone Infections, Acute Lymphadenitis, Impetigo, Skin Staph Infections, Pneumonia, Gonococcal Infections/Venereal Disease (Syphilis, Chlamydia, Inflammatory Diseases [Female Reproductive Organs]), Infections Of The Kidney, Cystitis/Uti, Acne, Hiv Disease/Asymptomatic Hiv, Cystic Fibrosis, Disorders Of The Immune System, Malignancy Neoplasms, Chronic Bronchitis, Emphysema, Bronchiectasis, Extrinsic Allergic Alveolitis, Chronic Airway Obstruction, Chronic Obstructive Asthma, Pneumoconiosis And Other Lung Disease Due To External Agents, Other Diseases Of The Respiratory System, And Tuberculosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9713	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9714	Patient Is Using Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9716	Bmi Is Documented As Being Outside Of Normal Parameters, Follow-Up Plan Is Not Completed For Documented Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9717	Documentation Stating The Patient Has Had A Diagnosis Of Bipolar Disorder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9719	Patient Is Not Ambulatory, Bed Ridden, Immobile, Confined To Chair, Wheelchair Bound, Dependent On Helper Pushing Wheelchair, Independent In Wheelchair Or Minimal Help In Wheelchair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9720	Hospice Services For Patient Occurred Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9721	Patient Not Ambulatory, Bed Ridden, Immobile, Confined To Chair, Wheelchair Bound, Dependent On Helper Pushing Wheelchair, Independent In Wheelchair Or Minimal Help In Wheelchair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9722	Documented History Of Renal Failure Or Baseline Serum Creatinine >= 4.0 Mg/Dl; Renal Transplant Recipients Are Not Considered To Have Preoperative Renal Failure, Unless, Since Transplantation The Cr Has Been Or Is 4.0 Or Higher	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9723	Hospice Services For Patient Received Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9724	Patients Who Had Documentation Of Use Of Anticoagulant Medications Overlapping The Measurement Year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9726	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9727	Patient Unable To Complete The Lepf Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9728	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9729	Patient Unable To Complete The Lepf Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9730	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9731	Patient Unable To Complete The Lepf Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9732	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9733	Patient Unable To Complete The Low Back Fs Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9734	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9735	Patient Unable To Complete The Shoulder Fs Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9736	Patient Refused To Participate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9737	Patient Unable To Complete The Elbow/Wrist/Hand Fs Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9740	Hospice Services Given To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9741	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9744	Patient Not Eligible Due To Active Diagnosis Of Hypertension	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9745	Documented Reason For Not Screening Or Recommending A Follow-Up For High Blood Pressure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9746	Patient Has Mitral Stenosis Or Prosthetic Heart Valves Or Patient Has Transient Or Reversible Cause Of Af (E.G., Pneumonia, Hyperthyroidism, Pregnancy, Cardiac Surgery)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9751	Patient Died At Any Time During The 24-Month Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9752	Emergency Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9753	Documentation Of Medical Reason For Not Conducting A Search For Dicom Format Images For Prior Patient Ct Imaging Studies Completed At Non-Affiliated External Healthcare Facilities Or Entities Within The Past 12 Months That Are Available Through A Secure, Authorized, Media-Free, Shared Archive (E.G., Trauma, Acute Myocardial Infarction, Stroke, Aortic Aneurysm Where Time Is Of The Essence)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9754	A Finding Of An Incidental Pulmonary Nodule	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9755	Documentation Of Medical Reason(S) For Not Including A Recommended Interval And Modality For Follow-Up Or For No Follow-Up, And Source Of Recommendations (E.G., Patients With Unexplained Fever, Immunocompromised Patients Who Are At Risk For Infection)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9756	Surgical Procedures That Included The Use Of Silicone Oil	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9757	Surgical Procedures That Included The Use Of Silicone Oil	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9758	Patient In Hospice At Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9760	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9761	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9762	Patient Had At Least Two Hpv Vaccines (With At Least 146 Days Between The Two) Or Three Hpv Vaccines On Or Between The Patient'S 9Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9763	Patient Did Not Have At Least Two Hpv Vaccines (With At Least 146 Days Between The Two) Or Three Hpv Vaccines On Or Between The Patient'S 9Th And 13Th Birthdays	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9764	Patient Has Been Treated With A Systemic Medication For Psoriasis Vulgaris	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9765	Documentation That The Patient Declined Change In Medication Or Alternative Therapies Were Unavailable, Has Documented Contraindications, Or Has Not Been Treated With A Systemic Medication For At Least Six Consecutive Months (E.G., Experienced Adverse Effects Or Lack Of Efficacy With All Other Therapy Options) In Order To Achieve Better Disease Control As Measured By Pga, Bsa, Pasi, Or Dlqi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9766	Patients Who Are Transferred From One Institution To Another With A Known Diagnosis Of Cva For Endovascular Stroke Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9767	Hospitalized Patients With Newly Diagnosed Cva Considered For Endovascular Stroke Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9768	Patients Who Utilize Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9769	Patient Had A Bone Mineral Density Test In The Past Two Years Or Received Osteoporosis Medication Or Therapy In The Past 12 Months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9770	Peripheral Nerve Block (Pnb)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9771	At Least 1 Body Temperature Measurement Equal To Or Greater Than 35.5 Degrees Celsius (Or 95.9 Degrees Fahrenheit) Achieved Within The 30 Minutes Immediately Before Or 15 Minutes Immediately After Anesthesia End Time	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9772	Documentation Of Medical Reason(S) For Not Achieving At Least 1 Body Temperature Measurement Equal To Or Greater Than 35.5 Degrees Celsius (Or 95.9 Degrees Fahrenheit) Within The 30 Minutes Immediately Before Or 15 Minutes Immediately After Anesthesia End Time (E.G., Emergency Cases, Intentional Hypothermia, Etc.)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9773	At Least 1 Body Temperature Measurement Equal To Or Greater Than 35.5 Degrees Celsius (Or 95.9 Degrees Fahrenheit) Not Achieved Within The 30 Minutes Immediately Before Or 15 Minutes Immediately After Anesthesia End Time, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9775	Patient Received At Least 2 Prophylactic Pharmacologic Anti-Emetic Agents Of Different Classes Preoperatively And/Or Intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9776	Documentation Of Medical Reason For Not Receiving At Least 2 Prophylactic Pharmacologic Anti-Emetic Agents Of Different Classes Preoperatively And/Or Intraoperatively (E.G., Intolerance Or Other Medical Reason)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9777	Patient Did Not Receive At Least 2 Prophylactic Pharmacologic Anti-Emetic Agents Of Different Classes Preoperatively And/Or Intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9779	Patients Who Are Breastfeeding At Any Time During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9780	Patients Who Have A Diagnosis Of Rhabdomyolysis At Any Time During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9781	Documentation Of Medical Reason(S) For Not Currently Being A Statin Therapy User Or Receiving An Order (Prescription) For Statin Therapy (E.G., Patients With Statin-Associated Muscle Symptoms Or An Allergy To Statin Medication Therapy, Patients Who Are Receiving Palliative Or Hospice Care, Patients With Active Liver Disease Or Hepatic Disease Or Insufficiency, Patients With End Stage Renal Disease [Esrd], Or Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9782	History Of Or Active Diagnosis Of Familial Hypercholesterolemia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9784	Pathologists/Dermatopathologists Providing A Second Opinion On A Biopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9785	Pathology Report Diagnosing Cutaneous Basal Cell Carcinoma, Squamous Cell Carcinoma, Or Melanoma (To Include In Situ Disease) Sent From The Pathologist/ Dermatopathologist To The Biopsying Clinician For Review Within 7 Days From The Time When The Tissue Specimen Was Received By The Pathologist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9786	Pathology Report Diagnosing Cutaneous Basal Cell Carcinoma, Squamous Cell Carcinoma, Or Melanoma (To Include In Situ Disease) Was Not Sent From The Pathologist/ Dermatopathologist To The Biopsying Clinician For Review Within 7 Days From The Time When The Tissue Specimen Was Received By The Pathologist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9787	Patient Alive As Of The Last Day Of The Measurement Year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9788	Most Recent Bp Is Less Than Or Equal To 140/90 Mm Hg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9789	Blood Pressure Recorded During Inpatient Stays, Emergency Room Visits, Or Urgent Care Visits	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9790	Most Recent Bp Is Greater Than 140/90 Mm Hg, Or Blood Pressure Not Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9791	Most Recent Tobacco Status Is Tobacco Free	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9792	Most Recent Tobacco Status Is Not Tobacco Free	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9793	Patient Is Currently On A Daily Aspirin Or Other Antiplatelet	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9794	Documentation Of Medical Reason(S) For Not On A Daily Aspirin Or Other Antiplatelet (E.G., History Of Gastrointestinal Bleed, Intra-Cranial Bleed, Idiopathic Thrombocytopenic Purpura (Itp), Gastric Bypass Or Documentation Of Active Anticoagulant Use During The Measurement Period)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9795	Patient Is Not Currently On A Daily Aspirin Or Other Antiplatelet	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9796	Patient Is Currently On A Statin Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9797	Patient Is Not On A Statin Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9805	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9806	Patients Who Received Cervical Cytology Or An Hpv Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9807	Patients Who Did Not Receive Cervical Cytology Or An Hpv Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9812	Patient Died Including All Deaths Occurring During The Hospitalization In Which The Operation Was Performed, Even If After 30 Days, And Those Deaths Occurring After Discharge From The Hospital, But Within 30 Days Of The Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9813	Patient Did Not Die Within 30 Days Of The Procedure Or During The Index Hospitalization	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9818	Documentation Of Sexual Activity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9819	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9820	Documentation Of A Chlamydia Screening Test With Proper Follow-Up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9821	No Documentation Of A Chlamydia Screening Test With Proper Follow-Up	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9822	Patients Who Had An Endometrial Ablation Procedure During The 12 Months Prior To The Index Date (Exclusive Of The Index Date)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9823	Endometrial Sampling Or Hysteroscopy With Biopsy And Results Documented During The 12 Months Prior To The Index Date (Exclusive Of The Index Date) Of The Endometrial Ablation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9824	Endometrial Sampling Or Hysteroscopy With Biopsy And Results Not Documented During The 12 Months Prior To The Index Date (Exclusive Of The Index Date) Of The Endometrial Ablation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9830	Her-2/Neu Positive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9831	Ajcc Stage At Breast Cancer Diagnosis = Ii Or Iii	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9832	Ajcc Stage At Breast Cancer Diagnosis = I (Ia Or Ib) And T-Stage At Breast Cancer Diagnosis Does Not Equal = T1, T1A, T1B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9838	Patient Has Metastatic Disease At Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999

G9839	Anti-Egfr Monoclonal Antibody Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9840	Ras (Kras And Nras) Gene Mutation Testing Performed Before Initiation Of Anti-Egfr Moab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9841	Ras (Kras And Nras) Gene Mutation Testing Not Performed Before Initiation Of Anti-Egfr Moab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9842	Patient Has Metastatic Disease At Diagnosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9843	Ras (Kras Or Nras) Gene Mutation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9844	Patient Did Not Receive Anti-Egfr Monoclonal Antibody Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9845	Patient Received Anti-Egfr Monoclonal Antibody Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9846	Patients Who Died From Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9847	Patient Received Systemic Cancer-Directed Therapy In The Last 14 Days Of Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9848	Patient Did Not Receive Systemic Cancer-Directed Therapy In The Last 14 Days Of Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9858	Patient Enrolled In Hospice	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9859	Patients Who Died From Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9860	Patient Spent Less Than Three Days In Hospice Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9861	Patient Spent Greater Than Or Equal To Three Days In Hospice Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9862	Documentation Of Medical Reason(S) For Not Recommending At Least A 10 Year Follow-Up Interval (E.G., Inadequate Prep, Familial Or Personal History Of Colonic Polyps, Patient Had No Adenoma And Age Is = 66 Years Old, Or Life Expectancy < 10 Years Old, Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
G9868	Receipt And Analysis Of Remote, Asynchronous Images For Dermatologic And/Or Ophthalmologic Evaluation, For Use Only In A Medicare-Approved Cmmi Model, Less Than 10 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9869	Receipt And Analysis Of Remote, Asynchronous Images For Dermatologic And/Or Ophthalmologic Evaluation, For Use Only In A Medicare-Approved Cmmi Model, 10-20 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9870	Receipt And Analysis Of Remote, Asynchronous Images For Dermatologic And/Or Ophthalmologic Evaluation, For Use Only In A Medicare-Approved Cmmi Model, More Than 20 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9873	First Medicare Diabetes Prevention Program (Mdpp) Core Session Was Attended By An Mdpp Beneficiary Under The Mdpp Expanded Model (Em). A Core Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 1 Through 6 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3)Adheres To A Cdc-Approved Dpp Curriculum For Core Sessions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999

G9874	Four Total Medicare Diabetes Prevention Program (Mdpp) Core Sessions Were Attended By An Mdpp Beneficiary Under The Mdpp Expanded Model (Em). A Core Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 1 Through 6 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Core Sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9875	Nine Total Medicare Diabetes Prevention Program (Mdpp) Core Sessions Were Attended By An Mdpp Beneficiary Under The Mdpp Expanded Model (Em). A Core Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 1 Through 6 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Core Sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9876	Two Medicare Diabetes Prevention Program (Mdpp) Core Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 7-9 Under The Mdpp Expanded Model (Em). A Core Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 7 Through 12 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions. The Beneficiary Did Not Achieve At Least 5% Weight Loss (Wl) From His/Her Baseline Weight, As Measured By At Least One In-Person Weight Measurement At A Core Maintenance Session In Months 7-9.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9877	Two Medicare Diabetes Prevention Program (Mdpp) Core Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 10-12 Under The Mdpp Expanded Model (Em). A Core Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 7 Through 12 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9878	Two Medicare Diabetes Prevention Program (Mdpp) Core Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 7-9 Under The Mdpp Expanded Model (Em). A Core Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 7 Through 12 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.The Beneficiary Achieved At Least 5% Weight Loss (Wl) From His/Her Baseline Weight, As Measured By At Least One In-Person Weight Measurement At A Core Maintenance Session In Months 7-9.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9879	Two Medicare Diabetes Prevention Program (Mdpp) Core Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 10-12 Under The Mdpp Expanded Model (Em). A Core Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 7 Through 12 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.The Beneficiary Achieved At Least 5% Weight Loss (Wl) From His/Her Baseline Weight, As Measured By At Least One In-Person Weight Measurement At A Core Maintenance Session In Months 10-12	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999

G9880	The Mdpp Beneficiary Achieved At Least 5% Weight Loss (WI) From His/Her Baseline Weight In Months 1-12 Of The Mdpp Services Period Under The Mdpp Expanded Model (Em). This Is A One-Time Payment Available When A Beneficiary First Achieves At Least 5% Weight Loss From Baseline As Measured By An In-Person Weight Measurement At A Core Session Or Core Maintenance Session.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9881	The Mdpp Beneficiary Achieved At Least 9% Weight Loss (WI) From His/Her Baseline Weight In Months 1-24 Under The Mdpp Expanded Model (Em). This Is A One-Time Payment Available When A Beneficiary First Achieves At Least 9% Weight Loss From Baseline As Measured By An In-Person Weight Measurement At A Core Session, Core Maintenance Session, Or Ongoing Maintenance Session.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9882	Two Medicare Diabetes Prevention Program (Mdpp) Ongoing Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 13-15 Under The Mdpp Expanded Model (Em). An Ongoing Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 13 Through 24 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.The Beneficiary Maintained At Least 5% Weight Loss (WI) From His/Her Baseline Weight, As Measured By At Least One In-Person Weight Measurement At An Ongoing Maintenance Session In Months 13-15.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9883	Two Medicare Diabetes Prevention Program (Mdpp) Ongoing Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 16-18 Under The Mdpp Expanded Model (Em). An Ongoing Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 13 Through 24 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9884	Two Medicare Diabetes Prevention Program (Mdpp) Ongoing Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 19-21 Under The Mdpp Expanded Model (Em). An Ongoing Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 13 Through 24 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions. The Beneficiary Maintained At Least 5% Weight Loss (WI) From His/Her Baseline Weight, As Measured By At Least One In-Person Weight Measurement At An Ongoing Maintenance Session In Months 19-21.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999
G9885	Two Medicare Diabetes Prevention Program (Mdpp) Ongoing Maintenance Sessions (Ms) Were Attended By An Mdpp Beneficiary In Months (Mo) 22-24 Under The Mdpp Expanded Model (Em). An Ongoing Maintenance Session Is An Mdpp Service That: (1) Is Furnished By An Mdpp Supplier During Months 13 Through 24 Of The Mdpp Services Period; (2) Is Approximately 1 Hour In Length; And (3) Adheres To A Cdc-Approved Dpp Curriculum For Maintenance Sessions.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2018	12/31/2999

G9886	Behavioral Counseling For Diabetes Prevention, In-Person, Group, 60 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
G9887	Behavioral Counseling For Diabetes Prevention, Distance Learning, 60 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
G9888	Maintenance 5% Wl From Baseline Weight In Months 7-12	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
G9890	Bridge Payment: A One-Time Payment For The First Medicare Diabetes Prevention Program (Mdpp) Core Session, Core Maintenance Session, Or Ongoing Maintenance Session Furnished By An Mdpp Supplier To An Mdpp Beneficiary During Months 1-24 Of The Mdpp Expanded Model (Em) Who Has Previously Received Mdpp Services From A Different Mdpp Supplier Under The Mdpp Expanded Model. A Supplier May Only Receive One Bridge Payment Per Mdpp Beneficiary.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9891	Mdpp Session Reported As A Line-Item On A Claim For A Payable Mdpp Expanded Model (Em) Hcpcs Code For A Session Furnished By The Billing Supplier Under The Mdpp Expanded Model And Counting Toward Achievement Of The Attendance Performance Goal For The Payable Mdpp Expanded Model Hcpcs Code.(This Code Is For Reporting Purposes Only).	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9892	Documentation Of Patient Reason(S) For Not Performing A Dilated Macular Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9893	Dilated Macular Exam Was Not Performed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9894	Androgen Deprivation Therapy Prescribed/Administered In Combination With External Beam Radiotherapy To The Prostate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9895	Documentation Of Medical Reason(S) For Not Prescribing/Administering Androgen Deprivation Therapy In Combination With External Beam Radiotherapy To The Prostate (E.G., Salvage Therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9896	Documentation Of Patient Reason(S) For Not Prescribing/Administering Androgen Deprivation Therapy In Combination With External Beam Radiotherapy To The Prostate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9897	Patients Who Were Not Prescribed/Administered Androgen Deprivation Therapy In Combination With External Beam Radiotherapy To The Prostate, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9898	Patients Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With Pos Code 32, 33, 34, 54, Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9899	Screening, Diagnostic, Film, Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Documented And Reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9900	Screening, Diagnostic, Film, Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Were Not Documented And Reviewed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9901	Patient Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With Pos Code 32, 33, 34, 54, Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9902	Patient Screened For Tobacco Use And Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999

G9903	Patient Screened For Tobacco Use And Identified As A Tobacco Non-User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9905	Patient Not Screened For Tobacco Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9906	Patient Identified As A Tobacco User Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9908	Patient Identified As Tobacco User Did Not Receive Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9910	Patients Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With Pos Code 32, 33, 34, 54 Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9911	Clinically Node Negative (T1N0M0 Or T2N0M0) Invasive Breast Cancer Before Or After Neoadjuvant Systemic Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9912	Hepatitis B Virus (Hbv) Status Assessed And Results Interpreted Prior To Initiating Anti-Tnf (Tumor Necrosis Factor) Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9913	Hepatitis B Virus (Hbv) Status Not Assessed And Results Interpreted Prior To Initiating Anti-Tnf (Tumor Necrosis Factor) Therapy, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9914	Patient Initiated An Anti-Tnf Agent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9915	No Record Of Hbv Results Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9916	Functional Status Performed Once In The Last 12 Months	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9917	Documentation Of Advanced Stage Dementia And Caregiver Knowledge Is Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9918	Functional Status Not Performed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9919	Screening Performed And Positive And Provision Of Recommendations	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9920	Screening Performed And Negative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9921	No Screening Performed, Partial Screening Performed Or Positive Screen Without Recommendations And Reason Is Not Given Or Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9922	Safety Concerns Screen Provided And If Positive Then Documented Mitigation Recommendations	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9923	Safety Concerns Screen Provided And Negative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9925	Safety Concerns Screening Not Provided, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9926	Safety Concerns Screening Positive Screen Is Without Provision Of Mitigation Recommendations, Including But Not Limited To Referral To Other Resources	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9928	Fda-Approved Anticoagulant Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999

G9929	Patient With Transient Or Reversible Cause Of Af (E.G., Pneumonia, Hyperthyroidism, Pregnancy, Cardiac Surgery)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9930	Patients Who Are Receiving Comfort Care Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9931	Documentation Of Cha2Ds2-Vasc Risk Score Of 0 Or 1 For Men; Or 0, 1, Or 2 For Women	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9938	Patients Aged 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long-Term Care With Pos Code 32, 33, 34, 54, Or 56 For More Than 90 Consecutive Days During The Six Months Prior To The Measurement Period Through December 31 Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9939	Pathologists/Dermatopathologists Is The Same Clinician Who Performed The Biopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9940	Documentation Of Medical Reason(S) For Not On A Statin (E.G., Pregnancy, In Vitro Fertilization, Clomiphene Rx, Esrd, Cirrhosis, Muscular Pain And Disease During The Measurement Period Or Prior Year)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9943	Back Pain Was Not Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9945	Patient Had Cancer, Acute Fracture Or Infection Related To The Lumbar Spine Or Patient Had Neuromuscular, Idiopathic Or Congenital Lumbar Scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9946	Back Pain Was Not Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9949	Leg Pain Was Not Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At Three Months (6 - 20 Weeks) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9954	Patient Exhibits 2 Or More Risk Factors For Post-Operative Vomiting	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9955	Cases In Which An Inhalational Anesthetic Is Used Only For Induction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9957	Documentation Of Medical Reason For Not Receiving Combination Therapy Consisting Of At Least Two Prophylactic Pharmacologic Anti-Emetic Agents Of Different Classes Preoperatively And/Or Intraoperatively (E.G., Intolerance Or Other Medical Reason)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9958	Patient Did Not Receive Combination Therapy Consisting Of At Least Two Prophylactic Pharmacologic Anti-Emetic Agents Of Different Classes Preoperatively And/Or Intraoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9959	Systemic Antimicrobials Not Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9960	Documentation Of Medical Reason(S) For Prescribing Systemic Antimicrobials	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9961	Systemic Antimicrobials Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9962	Embolization Endpoints Are Documented Separately For Each Embolized Vessel And Ovarian Artery Angiography Or Embolization Performed In The Presence Of Variant Uterine Artery Anatomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9963	Embolization Endpoints Are Not Documented Separately For Each Embolized Vessel Or Ovarian Artery Angiography Or Embolization Not Performed In The Presence Of Variant Uterine Artery Anatomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999

G9964	Patient Received At Least One Well-Child Visit With A Pcp During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9965	Patient Did Not Receive At Least One Well-Child Visit With A Pcp During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9968	Patient Was Referred To Another Clinician Or Specialist During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9969	Clinician Who Referred The Patient To Another Clinician Received A Report From The Clinician To Whom The Patient Was Referred	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9970	Clinician Who Referred The Patient To Another Clinician Did Not Receive A Report From The Clinician To Whom The Patient Was Referred	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9974	Dilated Macular Exam Performed, Including Documentation Of The Presence Or Absence Of Macular Thickening Or Geographic Atrophy Or Hemorrhage And The Level Of Macular Degeneration Severity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9975	Documentation Of Medical Reason(S) For Not Performing A Dilated Macular Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9976	Documentation Of Patient Reason(S) For Not Performing A Dilated Macular Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
G9977	Dilated Macular Exam Was Not Performed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
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.	1/1/2018	12/31/2999

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.	1/1/2018	12/31/2999
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.	10/1/2018	12/31/2999
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.	10/1/2018	12/31/2999

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.	10/1/2018	12/31/2999
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.	10/1/2018	12/31/2999
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.	10/1/2018	12/31/2999

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.	10/1/2018	12/31/2999
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.	10/1/2018	12/31/2999
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.	10/1/2018	12/31/2999
G9988	Palliative Care Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9990	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9991	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9992	Palliative Care Services Used By Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9993	Patient Was Provided Palliative Care Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999

G9994	Patient Is Using Palliative Care Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9996	Documentation Stating The Patient Has Received Or Is Currently Receiving Palliative Or Hospice Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9997	Documentation Of Patient Pregnancy Anytime During The Measurement Period Prior To And Including The Current Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9998	Documentation Of Medical Reason(S) For An Interval Of Less Than 3 Years Since The Last Colonoscopy (E.G., Last Colonoscopy Incomplete, Last Colonoscopy Had Inadequate Prep, Piecemeal Removal Of Adenomas, Or Sessile Serrated Polyps >= 20 Mm In Size, Last Colonoscopy Found Greater Than 10 Adenomas, Lower Gastrointestinal Bleeding, Or Patient At High Risk For Colon Cancer Due To Underlying Medical History ([I.E. Crohn'S Disease, Ulcerative Colitis, Personal Or Family History Of Colon Cancer, Hereditary Colorectal Cancer Syndromes])	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
G9999	Documentation Of System Reason(S) For An Interval Of Less Than 3 Years Since The Last Colonoscopy (E.G., Unable To Locate Previous Colonoscopy Report, Previous Colonoscopy Report Was Incomplete)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
H0041	Foster Care, Child, Non-Therapeutic, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H0042	Foster Care, Child, Non-Therapeutic, Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H0043	Supported Housing, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H0044	Supported Housing, Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H0051	Traditional Healing Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
H1010	Non-Medical Family Planning Education, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2015	Comprehensive Community Support Services, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
H2021	Community-Based Wrap-Around Services, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
H2023	Supported Employment, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2024	Supported Employment, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2025	Ongoing Support To Maintain Employment, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2026	Ongoing Support To Maintain Employment, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2030	Mental Health Clubhouse Services, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2031	Mental Health Clubhouse Services, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
H2038	Skills Training And Development, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2022	12/31/2999

J0172	Injection, Aducanumab-Avwa, 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J0174	Injection, Lecanemab-Irmb, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/6/2023	12/31/2999
J0175	Injection, Donanemab-Azbt, 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
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.	4/1/2024	12/31/2999
J0178	Injection, Aflibercept, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0179	Injection, Brolucizumab-Dbll, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J0202	Injection, Alemtuzumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
J0217	Injection, Velmanase Alfa-Tycv, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J0218	Injection, Olipudase Alfa-Rpcp, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J0219	Injection, Avalglucosidase Alfa-Ngpt, 4 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0220	Injection, Alglucosidase Alfa, 10 Mg, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0222	Injection, Patisiran, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J0223	Injection, Givosiran, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J0224	Injection, Lumasiran, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
J0225	Injection, Vutrisiran, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
J0248	Injection, Remdesivir, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999

J0270	Injection, Alprostadil, 1. 25 Mcg (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.	12/15/2014	12/31/2999
J0275	Alprostadil Urethral Suppository (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.	12/15/2014	12/31/2999
J0470	Injection, Dimercaprol, Per 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0485	Injection, Belatacept, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J0491	Injection, Anifrolumab-Fnia, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0517	Injection, Benralizumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0567	Injection, Cerliponase Alfa, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0584	Injection, Burosumab-Twza 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0585	Injection, Onabotulinumtoxina, 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	4/1/2024	12/31/2999
J0591	Injection, Deoxycholic Acid, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J0593	Injection, Lanadelumab-Flyo, 1 Mg (Code May Be Used For Medicare When Drug Administered Under 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.	10/1/2019	12/31/2999
J0599	Injection, C-1 Esterase Inhibitor (Human), (Haegarda), 10 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0600	Injection, Edetate Calcium Disodium, Up To 1000 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0717	Injection, Certolizumab Pegol, 1 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician, Not For Use When Drug Is Self Administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
J0775	Injection, Collagenase, Clostridium Histolyticum, 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

J0791	Injection, Crizanlizumab-Tmca, 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J0895	Injection, Deferoxamine Mesylate, 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0897	Injection, Denosumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2022	12/31/2999
J1071	Injection, Testosterone Cypionate, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
J1096	Dexamethasone, Lacrimal Ophthalmic Insert, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	4/1/2024	12/31/2999
J1301	Injection, Edaravone, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J1302	Injection, Sutimlimab-Jome, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J1303	Injection, Ravulizumab-Cwvz, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J1304	Injection, Tofersen, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J1305	Injection, Evinacumab-Dgnb, 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1306	Injection, Inclisiran, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1323	Injection, Elranatamab-Bcmm, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J1411	Injection, Etranacogene Dezaparvovec-Drlb, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1412	Injection, Valoctocogene Roxaparvovec-Rvox, Per Ml, Containing Nominal 2 X 10^13 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J1413	Injection, Delandistrogene Moxeparvovec-Rokl, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

J1426	Injection, Casimersen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1427	Injection, Viltolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
J1428	Injection, Eteplirsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
J1429	Injection, Golodirsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J1440	Fecal Microbiota, Live - Jslm, 1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1442	Injection, Filgrastim (G-Csf), Excludes Biosimilars, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1447	Injection, Tbo-Filgrastim, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1551	Injection, Immune Globulin (Cutaquig), 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1554	Injection, Immune Globulin (Asceniv), 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
J1576	Injection, Immune Globulin (Panzyga), Intravenous, Non-Lyophilized (E.G., Liquid), 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1620	Injection, Gonadorelin Hydrochloride, Per 100 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J1628	Injection, Guselkumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J1632	Injection, Brexanolone, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
J1726	Injection, Hydroxyprogesterone Caproate, (Makena), 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1729	Injection, Hydroxyprogesterone Caproate, Not Otherwise Specified, 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1746	Injection, Ibalizumab-Uiyk, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J1747	Injection, Spesolimab-Sbzo, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999

J1748	Injection, Infliximab-Dyyb (Zymfentra), 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
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.	1/1/2021	12/31/2999
J1930	Injection, Lanreotide, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2017	12/31/2999
J1932	Injection, Lanreotide, (Cipla), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J1950	Injection, Leuprolide Acetate (For Depot Suspension), Per 3. 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J1952	Leuprolide Injectable, Camcevi, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J2267	Injection, Mirikizumab-Mrkz, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J2327	Injection, Risankizumab-Rzaa, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
J2329	Injection, Ublituximab-Xiiy, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J2353	Injection, Octreotide, Depot Form For Intramuscular Injection, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2354	Injection, Octreotide, Non-Depot Form For Subcutaneous Or Intravenous Injection, 25 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2356	Injection, Tezepelumab-Ekko, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
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.	1/1/2013	12/31/2999
J2506	Injection, Pegfilgrastim, Excludes Biosimilar, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
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.	1/1/2024	12/31/2999
J2562	Injection, Plerixafor, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

J2777	Injection, Faricimab-Svoa, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J2778	Injection, Ranibizumab, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J2779	Injection, Ranibizumab, Via Intravitreal Implant (Susvimo), 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J2781	Injection, Pegcetacoplan, Intravitreal, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
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.	4/1/2024	12/31/2999
J2787	Riboflavin 5'-Phosphate, Ophthalmic Solution, Up To 3 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
J2796	Injection, Romiplostim, 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2820	Injection, Sargramostim (Gm-Csf), 50 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
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.	10/1/2020	12/31/2999
J3055	Injection, Talquetamab-Tgvs, 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
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.	10/1/2019	12/31/2999
J3121	Injection, Testosterone Enanthate, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
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.	10/1/2024	12/31/2999
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.	10/1/2020	12/31/2999
J3245	Injection, Tildrakizumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J3247	Injection, Secukinumab, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999

J3299	Injection, Triamcinolone Acetonide (Xipere), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J3316	Injection, Triptorelin, Extended-Release, 3.75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
J3355	Injection, Urofollitropin, 75 Iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
J3393	Injection, Betibeglogene Autotemcel, Per Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J3394	Injection, Lovotibeglogene Autotemcel, Per Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J3396	Injection, Verteporfin, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
J3398	Injection, Voretigene Neparvovec-Rzyl, 1 Billion Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J3399	Injection, Onasemnogene Abeparvovec-Xioi, Per Treatment, Up To 5X10^15 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J3401	Beremagene Geperpavec-Svdt For Topical Administration, Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes, Per 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J3520	Edetate Disodium, Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J3570	Laetrile, Amygdalin, Vitamin B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
J7183	Injection, Von Willebrand Factor Complex (Human), Wilate, 1 I.U. Vwf:Rco	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J7308	Aminolevulinic Acid Hcl For Topical Administration, 20%, Single Unit Dosage Form (354 Mg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
J7311	Injection, Fluocinolone Acetonide, Intravitreal Implant (Retisert), 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J7312	Injection, Dexamethasone, Intravitreal Implant, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J7313	Injection, Fluocinolone Acetonide, Intravitreal Implant (Iluvien), 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999

J7314	Injection, Fluocinolone Acetonide, Intravitreal Implant (Yutiq), 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J7330	Autologous Cultured Chondrocytes, Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J7331	Hyaluronan Or Derivative, Synojoynt, For Intra-Articular Injection, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J7332	Hyaluronan Or Derivative, Triluron, For Intra-Articular Injection, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
J7340	Carbidopa 5 Mg/Levodopa 20 Mg Enteral Suspension, 100 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
J7345	Aminolevulinic Acid Hcl For Topical Administration, 10% Gel, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
J7351	Injection, Bimatoprost, Intracameral Implant, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
J7355	Injection, Travoprost, Intracameral Implant, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
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.	4/1/2021	12/31/2999
J7508	Tacrolimus, Extended Release, (Astagraf Xl), Oral, 0.1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
J7604	Acetylcysteine, Inhalation Solution, Compounded Product, Administered Through	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7607	Levalbuterol, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, 0.5 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7609	Albuterol, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose, 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7610	Albuterol, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7615	Levalbuterol, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose, 0.5 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7622	Beclomethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7624	Betamethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7627	Budesonide, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Up To 0.5 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7628	Bitolterol Mesylate, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7629	Bitolterol Mesylate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

J7632	Cromolyn Sodium, Inhalation Solution, Compounded Product, Administered Through	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7634	Budesonide, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per 0.25 Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7635	Atropine, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7636	Atropine, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7637	Dexamethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7638	Dexamethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7640	Formoterol, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, 12 Micrograms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7641	Flunisolide, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7642	Glycopyrrolate, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7643	Glycopyrrolate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7645	Ipratropium Bromide, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7647	Isoetharine Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7650	Isoetharine Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7657	Isoproterenol Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7660	Isoproterenol Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7667	Metaproterenol Sulfate, Inhalation Solution, Compounded Product, Concentrated Form, Per 10 Milligrams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7670	Metaproterenol Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per 10 Milligrams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7676	Pentamidine Isethionate, Inhalation Solution, Compounded Product, Administered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7680	Terbutaline Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7681	Terbutaline Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7683	Triamcinolone, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7684	Triamcinolone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7685	Tobramycin, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per 300 Milligrams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
J7999	Compounded Drug, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999

J9021	Injection, Asparaginase, Recombinant, (Rylaze), 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
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.	7/1/2023	12/31/2999
J9032	Injection, Belinostat, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
J9036	Injection, Bendamustine Hydrochloride, (Belrapzo/Bendamustine), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2019	12/31/2999
J9056	Injection, Bendamustine Hydrochloride (Vivimusta), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9058	Injection, Bendamustine Hydrochloride (Apotex), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9059	Injection, Bendamustine Hydrochloride (Baxter), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9061	Injection, Amivantamab-Vmjw, 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J9153	Injection, Liposomal, 1 Mg Daunorubicin And 2.27 Mg Cytarabine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
J9155	Injection, Degarelix, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J9202	Goserelin Acetate Implant, Per 3. 6 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J9206	Injection, Irinotecan, 20 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
J9225	Histrelin Implant (Vantas), 50 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J9226	Histrelin Implant (Supprelin La), 50 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J9247	Injection, Melphalan Flufenamide, 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J9259	Injection, Paclitaxel Protein-Bound Particles (American Regent), Not Therapeutically Equivalent To J9264, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9262	Injection, Omacetaxine Mepesuccinate, 0.01 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

J9272	Injection, Dostarlimab-Gxly, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J9273	Injection, Tisotumab Vedotin-Tftv, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J9274	Injection, Tebentafusp-Tebn, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J9285	Injection, Olaratumab, 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2019	12/31/2999
J9286	Injection, Glofitamab-Gxbm, 2.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J9295	Injection, Necitumumab, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
J9311	Injection, Rituximab 10 Mg And Hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J9312	Injection, Rituximab, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J9321	Injection, Epcoritamab-Bysp, 0.16 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J9325	Injection, Talimogene Laherparepvec, Per 1 Million Plaque Forming Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
J9331	Injection, Sirolimus Protein-Bound Particles, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J9332	Injection, Efgartigimod Alfa-Fcab, 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J9333	Injection, Rozanolixizumab-Noli, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J9334	Injection, Efgartigimod Alfa, 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J9350	Injection, Mosunetuzumab-Axgb, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9359	Injection, Loncastuximab Tesirine-Lpyl, 0.075 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
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.	4/1/2024	12/31/2999

J9380	Injection, Teclistamab-Cqyv, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9381	Injection, Teplizumab-Mzwv, 5 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J9400	Injection, Ziv-Aflibercept, 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
J9600	Injection, Porfimer Sodium, 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0002	Standard Hemi (Low Seat) Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
K0003	Lightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0004	High Strength, Lightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0006	Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0007	Extra Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0008	Custom Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2013	12/31/2999
K0009	Other Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0010	Standard - Weight Frame Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0011	Standard - Weight Frame Motorized/Power Wheelchair With Programmable Control Parameters For Speed Adjustment, Tremor Dampening, Acceleration Control And Braking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0012	Lightweight Portable Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2013	12/31/2999
K0014	Other Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

K0046	Elevating Legrest, Lower Extension Tube, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0047	Elevating Legrest, Upper Hanger Bracket, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0051	Cam Release Assembly, Footrest Or Legrest, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0053	Elevating Footrests, Articulating (Telescoping), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0056	Seat Height Less Than 17 Or Equal To Or Greater Than 21 For A High Strength, Lightweight, Or Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0065	Spoke Protectors, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
K0070	Rear Wheel Assembly, Complete, With Pneumatic Tire, Spokes Or Molded, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0071	Front Caster Assembly, Complete, With Pneumatic Tire, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0072	Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0108	Wheelchair Component Or Accessory, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0195	Elevating Leg Rests, Pair (For Use With Capped Rental Wheelchair Base)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
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.	2/1/2015	12/31/2999
K0462	Temporary Replacement For Patient Owned Equipment Being Repaired, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
K0669	Seat/Back Custom; No Dme Pdac Ver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0743	Suction Pump, Home Model, Portable, For Use On Wounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0744	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size 16 Square Inches Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0745	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

K0746	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size Greater Than 48 Square Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0800	Power Operated Vehicle, Group 1 Standard, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0801	Power Operated Vehicle, Group 1 Heavy Duty, Patient Weight Capacity, 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0802	Power Operated Vehicle, Group 1 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0806	Power Operated Vehicle, Group 2 Standard, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0807	Power Operated Vehicle, Group 2 Heavy Duty, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0808	Power Operated Vehicle, Group 2 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0812	Power Operated Vehicle, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0813	Power Wheelchair, Group 1 Standard, Portable, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0814	Power Wheelchair, Group 1 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0815	Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0816	Power Wheelchair, Group 1 Standard, Captains Chair, Patient Weight Capactiy Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0820	Power Wheelchair, Group 2 Standard, Portable, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0821	Power Wheelchair, Group 2 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0822	Power Wheelchair, Group 2 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0823	Power Wheelchair, Group 2 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

K0824	Power Wheelchair, Group 2 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
K0826	Power Wheelchair, Group 2 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0827	Power Wheelchair, Group 2 Very Heavy Duty, Captains Chair, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0828	Power Wheelchair, Group 2 Extra Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0829	Power Wheelchair, Group 2 Extra Heavy Duty, Captains Chair, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0830	Power Wheelchair, Group 2 Standard, Seat Elevator, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0831	Power Wheelchair, Group 2 Standard, Seat Elevator, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0835	Power Wheelchair, Group 2 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0836	Power Wheelchair, Group 2 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0837	Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0838	Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0839	Power Wheelchair, Group 2 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0840	Power Wheelchair, Group 2 Extra Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0841	Power Wheelchair, Group 2 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0842	Power Wheelchair, Group 2 Standard, Multiple Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

K0843	Power Wheelchair, Group 2 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0848	Power Wheelchair, Group 3 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
K0850	Power Wheelchair, Group 3 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0851	Power Wheelchair, Group 3 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0852	Power Wheelchair, Group 3 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0853	Power Wheelchair, Group 3 Very Heavy Duty, Captains Chair, Patient Weight Capacity, 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0854	Power Wheelchair, Group 3 Extra Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0855	Power Wheelchair, Group 3 Extra Heavy Duty, Captains Chair, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0856	Power Wheelchair, Group 3 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0857	Power Wheelchair, Group 3 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0858	Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0859	Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0860	Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0861	Power Wheelchair, Group 3 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0862	Power Wheelchair, Group 3 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

K0863	Power Wheelchair, Group 3 Very Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0864	Power Wheelchair, Group 3 Extra Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0868	Power Wheelchair, Group 4 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
K0870	Power Wheelchair, Group 4 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0871	Power Wheelchair, Group 4 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0877	Power Wheelchair, Group 4 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0878	Power Wheelchair, Group 4 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0879	Power Wheelchair, Group 4 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0880	Power Wheelchair, Group 4 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0884	Power Wheelchair, Group 4 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0885	Power Wheelchair, Group 4 Standard, Multiple Power Option, Captains Chair, Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0886	Power Wheelchair, Group 4 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0890	Power Wheelchair, Group 5 Pediatric, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0891	Power Wheelchair, Group 5 Pediatric, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
K0898	Power Wheelchair, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

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.	1/1/2013	12/31/2999
K0900	Customized Durable Medical Equipment, Other Than Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2013	12/31/2999
K1004	Low Frequency Ultrasonic Diathermy Treatment Device For Home Use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
K1007	Bilateral Hip, Knee, Ankle, Foot Device, Powered, Includes Pelvic Component, Single Or Double Upright(S), Knee Joints Any Type, With Or Without Ankle Joints Any Type, Includes All Components And Accessories, Motors, Microprocessors, Sensors	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
K1027	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Without Fixed Mechanical Hinge, Custom Fabricated, Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
K1030	External Recharging System For Battery (Internal) For Use With Implanted Cardiac Contractility Modulation Generator, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
K1035	Molecular Diagnostic Test Reader, Nonprescription Self-Administered And Self-Collected Use, Fda Approved, Authorized Or Cleared	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	12/31/2999
K1036	Supplies And Accessories (E.G., Transducer) For Low Frequency Ultrasonic Diathermy Treatment Device, Per Month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
K1037	Docking Station For Use With Oral Device/Appliance Used To Reduce Upper Airway Collapsibility	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
L1320	Thoracic, Pectus Carinatum Orthosis, Sternal Compression, Rigid Circumferential Frame With Anterior And Posterior Rigid Pads, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L1834	Knee Orthosis, Without Knee Joint, Rigid, Custom-Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L1840	Knee Orthosis, Derotation, Medial-Lateral, Anterior Cruciate Ligament, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L1844	Knee Orthosis, Single Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation Control, With Or Without Varus/Valgus Adjustment, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L1846	Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation Control, With Or Without Varus/Valgus Adjustment, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L1860	Knee Orthosis, Modification Of Supracondylar Prosthetic Socket, Custom-Fabricated (Sk)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L2006	Knee Ankle Foot Device, Any Material, Single Or Double Upright, Swing And Stance Phase Microprocessor Control With Adjustability, Includes All Components (E.G., Sensors, Batteries, Charger), Any Type Activation, With Or Without Ankle Joint(S), Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
L3000	Foot, Insert, Removable, Molded To Patient Model, 'Ucb' Type, Berkeley Shell, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3001	Foot, Insert, Removable, Molded To Patient Model, Spenco, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3002	Foot, Insert, Removable, Molded To Patient Model, Plastazote Or Equal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3003	Foot, Insert, Removable, Molded To Patient Model, Silicone Gel, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3010	Foot, Insert, Removable, Molded To Patient Model, Longitudinal Arch Support, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3020	Foot, Insert, Removable, Molded To Patient Model, Longitudinal/ Metatarsal Support, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3030	Foot, Insert, Removable, Formed To Patient Foot, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3031	Foot, Insert/Plate, Removable, Addition To Lower Extremity Orthosis, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3040	Foot, Arch Support, Removable, Premolded, Longitudinal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3050	Foot, Arch Support, Removable, Premolded, Metatarsal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3060	Foot, Arch Support, Removable, Premolded, Longitudinal/ Metatarsal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3070	Foot, Arch Support, Non-Removable Attached To Shoe, Longitudinal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3080	Foot, Arch Support, Non-Removable Attached To Shoe, Metatarsal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3090	Foot, Arch Support, Non-Removable Attached To Shoe, Longitudinal/Metatarsal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3100	Hallus-Valgus Night Dynamic Splint, Prefabricated, Off-The-Shelf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3140	Foot, Abduction Rotation Bar, Including Shoes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3150	Foot, Abduction Rotatation Bar, Without Shoes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3160	Foot, Adjustable Shoe-Styled Positioning Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3170	Foot, Plastic, Silicone Or Equal, Heel Stabilizer, Prafabricated, Off-The-Shelf, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3201	Orthopedic Shoe, Oxford With Supinator Or Pronator, Infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3202	Orthopedic Shoe, Oxford With Supinator Or Pronator, Child	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3203	Orthopedic Shoe, Oxford With Supinator Or Pronator, Junior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

L3204	Orthopedic Shoe, Hightop With Supinator Or Pronator, Infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3206	Orthopedic Shoe, Hightop With Supinator Or Pronator, Child	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3207	Orthopedic Shoe, Hightop With Supinator Or Pronator, Junior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
L3212	Benesch Boot, Pair, Infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3213	Benesch Boot, Pair, Child	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3214	Benesch Boot, Pair, Junior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3215	Orthopedic Footwear, Ladies Shoe, Oxford, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3216	Orthopedic Footwear, Ladies Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3217	Orthopedic Footwear, Ladies Shoe, Hightop, Depth Inlay, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3219	Orthopedic Footwear, Mens Shoe, Oxford, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3221	Orthopedic Footwear, Mens Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3222	Orthopedic Footwear, Mens Shoe, Hightop, Depth Inlay, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3230	Orthopedic Footwear, Custom Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3250	Orthopedic Footwear, Custom Molded Shoe, Removable Inner Mold, Prosthetic Shoe, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3251	Foot, Shoe Molded To Patient Model, Silicone Shoe, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3252	Foot, Shoe Molded To Patient Model, Plastazote (Or Similar), Custom Fabricated, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3253	Foot, Molded Shoe Plastazote (Or Similar) Custom Fitted, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3254	Non-Standard Size Or Width	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3255	Non-Standard Size Or Length	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3257	Orthopedic Footwear, Additional Charge For Split Size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3265	Plastazote Sandal, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3300	Lift, Elevation, Heel, Tapered To Metatarsals, Per Inch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3310	Lift, Elevation, Heel And Sole, Neoprene, Per Inch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3320	Lift, Elevation, Heel And Sole, Cork, Per Inch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3330	Lift, Elevation, Metal Extension (Skate)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

L3332	Lift, Elevation, Inside Shoe, Tapered, Up To One-Half Inch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3334	Lift, Elevation, Heel, Per Inch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3340	Heel Wedge, Sach	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3350	Heel Wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3360	Sole Wedge, Outside Sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3370	Sole Wedge, Between Sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3380	Clubfoot Wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3390	Outflare Wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3400	Metatarsal Bar Wedge, Rocker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3410	Metatarsal Bar Wedge, Between Sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3420	Full Sole And Heel Wedge, Between Sole	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3430	Heel, Counter, Plastic Reinforced	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3440	Heel, Counter, Leather Reinforced	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3450	Heel, Sach Cushion Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3455	Heel, New Leather, Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3460	Heel, New Rubber, Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3465	Heel, Thomas With Wedge	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3470	Heel, Thomas Extended To Ball	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3480	Heel, Pad And Depression For Spur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3485	Heel, Pad, Removable For Spur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3500	Orthopedic Shoe Addition, Insole, Leather	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3510	Orthopedic Shoe Addition, Insole, Rubber	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3520	Orthopedic Shoe Addition, Insole, Felt Covered With Leather	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3530	Orthopedic Shoe Addition, Sole, Half	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3540	Orthopedic Shoe Addition, Sole, Full	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999

L3550	Orthopedic Shoe Addition, Toe Tap Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3560	Orthopedic Shoe Addition, Toe Tap, Horseshoe	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3570	Orthopedic Shoe Addition, Special Extension To Instep (Leather With Eyelets)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3580	Orthopedic Shoe Addition, Convert Instep To Velcro Closure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3590	Orthopedic Shoe Addition, Convert Firm Shoe Counter To Soft Counter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3595	Orthopedic Shoe Addition, March Bar	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3600	Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, Existing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3610	Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, New	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3620	Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, Existing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3630	Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, New	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3640	Transfer Of An Orthosis From One Shoe To Another, Dennis Browne Splint (Riveton), Both Shoes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L3649	Orthopedic Shoe, Modification, Addition Or Transfer, Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
L5610	Addition To Lower Extremity, Endoskeletal System, Above Knee, Hydracadence System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5611	Addition To Lower Extremity, Endoskeletal System, Above Knee - Knee Disarticulation, 4 Bar Linkage, With Friction Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5613	Addition To Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, With Hydraulic Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5614	Addition To Lower Extremity, Exoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, With Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5615	Addition, Endoskeletal Knee-Shin System, 4 Bar Linkage Or Multiaxial, Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
L5616	Addition To Lower Extremity, Endoskeletal System, Above Knee, Universal Multiplex System, Friction Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5620	Addition To Lower Extremity, Test Socket, Below Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5624	Addition To Lower Extremity, Test Socket, Above Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L5629	Addition To Lower Extremity, Below Knee, Acrylic Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5631	Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Acrylic Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5638	Addition To Lower Extremity, Below Knee, Leather Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5639	Addition To Lower Extremity, Below Knee, Wood Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5640	Addition To Lower Extremity, Knee Disarticulation, Leather Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5642	Addition To Lower Extremity, Above Knee, Leather Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5644	Addition To Lower Extremity, Above Knee, Wood Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5645	Addition To Lower Extremity, Below Knee, Flexible Inner Socket, External Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5646	Addition To Lower Extremity, Below Knee, Air, Fluid, Gel Or Equal, Cushion Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5647	Addition To Lower Extremity, Below Knee Suction Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5648	Addition To Lower Extremity, Above Knee, Air, Fluid, Gel Or Equal, Cushion Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5651	Addition To Lower Extremity, Above Knee, Flexible Inner Socket, External Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5652	Addition To Lower Extremity, Suction Suspension, Above Knee Or Knee Disarticulation Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5670	Addition To Lower Extremity, Below Knee, Molded Supracondylar Suspension ('Pts' Or Similar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5671	Addition To Lower Extremity, Below Knee / Above Knee Suspension Locking Mechanism (Shuttle, Lanyard Or Equal), Excludes Socket Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
L5672	Addition To Lower Extremity, Below Knee, Removable Medial Brim Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999

L5673	Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated From Existing Mold Or Prefabricated, Socket Insert, Silicone Gel, Elastomeric Or Equal, For Use With Locking Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
L5704	Custom Shaped Protective Cover, Below Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5705	Custom Shaped Protective Cover, Above Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5706	Custom Shaped Protective Cover, Knee Disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5707	Custom Shaped Protective Cover, Hip Disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	12/31/2999
L5714	Addition, Exoskeletal Knee-Shin System, Single Axis, Variable Friction Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5722	Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5724	Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5726	Addition, Exoskeletal Knee-Shin System, Single Axis, External Joints Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5728	Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5780	Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic/Hydra Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5785	Addition, Exoskeletal System, Below Knee, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5790	Addition, Exoskeletal System, Above Knee, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5795	Addition, Exoskeletal System, Hip Disarticulation, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5814	Addition, Endoskeletal Knee-Shin System, Polycentric, Hydraulic Swing Phase Control, Mechanical Stance Phase Lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5816	Addition, Endoskeletal Knee-Shin System, Polycentric, Mechanical Stance Phase Lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L5818	Addition, Endoskeletal Knee-Shin System, Polycentric, Friction Swing, And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5822	Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5824	Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5826	Addition, Endoskeletal Knee-Shin System, Single Axis, Hydraulic Swing Phase Control, With Miniature High Activity Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5828	Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5830	Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic/ Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5840	Addition, Endoskeletal Knee/Shin System, 4-Bar Linkage Or Multiaxial, Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L5841	Addition, Endoskeletal Knee-Shin System, Polycentric, Pneumatic Swing, And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L5848	Addition To Endoskeletal Knee-Shin System, Fluid Stance Extension, Dampening Feature, With Or Without Adjustability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5856	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Microprocessor Control Feature, Swing And Stance Phase, Includes Electronic Sensor(S), Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	9/1/2020	12/31/2999
L5858	Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System, Microprocessor Control Feature, Stance Phase Only, Includes Electronic Sensor(S), Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5859	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Powered And Programmable Flexion/Extension Assist Control, Includes Any Type Motor(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5926	Addition To Lower Extremity Prosthesis, Endoskeletal, Knee Disarticulation, Above Knee, Hip Disarticulation, Positional Rotation Unit, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
L5961	Addition, Endoskeletal System, Polycentric Hip Joint, Pneumatic Or Hydraulic Control, Rotation Control, With Or Without Flexion And/Or Extension Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5962	Addition, Endoskeletal System, Below Knee, Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L5964	Addition, Endoskeletal System, Above Knee, Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5966	Addition, Endoskeletal System, Hip Disarticulation, Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5968	Addition To Lower Limb Prosthesis, Multiaxial Ankle With Swing Phase Active Dorsiflexion Feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2015	12/31/2999
L5969	Addition, Endoskeletal Ankle-Foot Or Ankle System, Power Assist, Includes Any Type Motor(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
L5970	All Lower Extremity Prostheses, Foot, External Keel, Sach Foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5973	Endoskeletal Ankle Foot System, Microprocessor Controlled Feature, Dorsiflexion And/Or Plantar Flexion Control, Includes Power Source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
L5976	All Lower Extremity Prostheses, Energy Storing Foot (Seattle Carbon Copy Ii Or Equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5978	All Lower Extremity Prostheses, Foot, Multiaxial Ankle/Foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5979	All Lower Extremity Prosthesis, Multi-Axial Ankle, Dynamic Response Foot, One Piece System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5980	All Lower Extremity Prostheses, Flex Foot System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5981	All Lower Extremity Prostheses, Flex-Walk System Or Equal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5982	All Exoskeletal Lower Extremity Prostheses, Axial Rotation Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5984	All Endoskeletal Lower Extremity Prosthesis, Axial Rotation Unit, With Or Without Adjustability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5985	All Endoskeletal Lower Extremity Prostheses, Dynamic Prosthetic Pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5986	All Lower Extremity Prostheses, Multi-Axial Rotation Unit ('Mcp' Or Equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5987	All Lower Extremity Prosthesis, Shank Foot System With Vertical Loading Pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L5991	Addition To Lower Extremity Prostheses, Osseointegrated External Prosthetic Connector	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
L6026	Transcarpal/Metacarpal Or Partial Hand Disarticulation Prosthesis, External Power, Self-Suspended, Inner Socket With Removable Forearm Section, Electrodes And Cables, Two Batteries, Charger, Myoelectric Control Of Terminal Device, Excludes Terminal Device(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L6611	Addition To Upper Extremity Prosthesis, External Powered, Additional Switch, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L6621	Upper Extremity Prosthesis Addition, Flexion/Extension Wrist With Or Without Friction, For Use With External Powered Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L6646	Upper Extremity Addition, Shoulder Joint, Multipositional Locking, Flexion, Adjustable Abduction Friction Control, For Use With Body Powered Or External Powered System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2016	12/31/2999
L6648	Upper Extremity Addition, Shoulder Lock Mechanism, External Powered Actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2016	12/31/2999
L6715	Terminal Device, Multiple Articulating Digit, Includes Motor(S), Initial Issue Or Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	2/15/2014	12/31/2999
L6881	Automatic Grasp Feature, Addition To Upper Limb Electric Prosthetic Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L6882	Microprocessor Control Feature, Addition To Upper Limb Prosthetic Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6883	Replacement Socket, Below Elbow/Wrist Disarticulation, Molded To Patient Model, For Use With Or Without External Power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L6884	Replacement Socket, Above Elbow/Elbow Disarticulation, Molded To Patient Model, For Use With Or Without External Power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L6885	Replacement Socket, Shoulder Disarticulation/Interscapular Thoracic, Molded To Patient Model, For Use With Or Without External Power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6920	Wrist Disarticulation, External Power, Self-Suspended Inner Socket, Removable Forearm Shell, Otto Bock Or Equal, Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
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.	2/15/2014	12/31/2999
L6930	Below Elbow, External Power, Self-Suspended Inner Socket, Removable Forearm Shell, Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999

L6935	Below Elbow, External Power, Self-Suspended Inner Socket, Removable Forearm Shell, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6940	Elbow Disarticulation, External Power, Molded Inner Socket, Removable Humeral Shell, Outside Locking Hinges, Forearm, Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6945	Elbow Disarticulation, External Power, Molded Inner Socket, Removable Humeral Shell, Outside Locking Hinges, Forearm, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6950	Above Elbow, External Power, Molded Inner Socket, Removable Humeral Shell, Internal Locking Elbow, Forearm, Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6955	Above Elbow, External Power, Molded Inner Socket, Removable Humeral Shell, Internal Locking Elbow, Forearm, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6960	Shoulder Disarticulation, External Power, Molded Inner Socket, Removable Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm, Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6965	Shoulder Disarticulation, External Power, Molded Inner Socket, Removable Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6970	Interscapular-Thoracic, External Power, Molded Inner Socket, Removable Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm, Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L6975	Interscapular-Thoracic, External Power, Molded Inner Socket, Removable Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7007	Electric Hand, Switch Or Myoelectric Controlled, Adult	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7008	Electric Hand, Switch Or Myoelectric, Controlled, Pediatric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
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.	2/15/2014	12/31/2999
L7040	Prehensile Actuator, Switch Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999

L7045	Electric Hook, Switch Or Myoelectric Ontrolled, Pediatric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7170	Electronic Elbow, Hosmer Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7180	Electronic Elbow, Microprocessor Sequential Control Of Elbow And Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7181	Electronic Elbow, Microprocessor Simultaneous Control Of Elbow And Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7185	Electronic Elbow, Adolescent, Variety Village Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7186	Electronic Elbow, Child, Variety Village Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7190	Electronic Elbow, Adolescent, Variety Village Or Equal, Myoelectronically Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7191	Electronic Elbow, Child, Variety Village Or Equal, Myoelectronically Controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2014	12/31/2999
L7259	Electronic Wrist Rotator, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7360	Six Volt Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7362	Battery Charger, Six Volt, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7364	Twelve Volt Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2016	12/31/2999
L7366	Battery Charger, Twelve Volt, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2016	12/31/2999
L7367	Lithium Ion Battery, Rechargeable, Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7368	Lithium Ion Battery Charger, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7900	Male Vacuum Erection System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

L7902	Tension Ring, For Vacuum Erection Device, Any Type, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2022	12/31/2999
L8600	Implantable Breast Prosthesis, Silicone Or Equal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2016	12/31/2999
L8603	Injectable Bulking Agent, Collagen Implant, Urinary Tract, 2. 5 Ml Syringe, Includes Shipping And Necessary Supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
L8604	Injectable Bulking Agent, Dextranomer/Hyaluronic Acid Copolymer Implant, Urinary Tract, 1 Ml, Includes Shipping And Necessary Supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L8605	Injectable Bulking Agent, Dextranomer/Hyaluronic Acid Copolymer Implant, Anal Canal, 1 Ml, Includes Shipping And Necessary Supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
L8606	Injectable Bulking Agent, Synthetic Implant, Urinary Tract, 1 Ml Syringe, Includes Shipping And Necessary Supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L8609	Artificial Cornea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L8612	Aqueous Shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
L8613	Ossicula Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2022	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999

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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
L8625	External Recharging System For Battery For Use With Cochlear Implant Or Auditory Osseointegrated Device, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
L8678	Electrical Stimulator Supplies (External) For Use With Implantable Neurostimulator, Per Month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8684	Radiofrequency Transmitter (External) For Use With Implantable Sacral Root Neurostimulator Receiver For Bowel And Bladder Management, Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
L8692	Auditory Osseointegrated Device, External Sound Processor, Used Without Osseointegration, Body Worn, Includes Headband Or Other Means Of External Attachment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
L8694	Auditory Osseointegrated Device, Transducer/Actuator, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
L8698	Miscellaneous Component, Supply Or Accessory For Use With Total Artificial Heart System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
L8701	Powered Upper Extremity Range Of Motion Assist Device, Elbow, Wrist, Hand With Single Or Double Upright(S), Includes Microprocessor, Sensors, All Components And Accessories, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999

L8702	Powered Upper Extremity Range Of Motion Assist Device, Elbow, Wrist, Hand, Finger, Single Or Double Upright(S), Includes Microprocessor, Sensors, All Components And Accessories, Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
M0001	Advancing Cancer Care Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M0002	Optimal Care For Kidney Health Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M0003	Optimal Care For Patients With Episodic Neurological Conditions Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M0004	Supportive Care For Neurodegenerative Conditions Mips Value Pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M0005	Value In Primary Care Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M0010	Enhancing Oncology Model (Eom) Monthly Enhanced Oncology Services (Meos) Payment For Eom Enhanced Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	12/31/2999
M0075	Cellular Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
M0224	Intravenous Infusion, Pemivibart, For The Pre-Exposure Prophylaxis Only, For Certain Adults And Adolescents (12 Years Of Age And Older Weighing At Least 40 Kg) With No Known Sars-Cov-2 Exposure, Who Either Have Moderate-To-Severe Immune Compromise Due To A Medical Condition Or Receipt Of Immunosuppressive Medications Or Treatments, Includes Infusion And Post Administration Monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/22/2024	12/31/2999
M0240	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring, Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0241	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring In The Home Or Residence, This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency, Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0243	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0244	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0245	Intravenous Infusion, Bamlanivimab And Etesevimab, Includes Infusion And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999

M0246	Intravenous Infusion, Bamlanivimab And Etesevimab, Includes Infusion And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider Based To The Hospital During The Covid 19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0300	Iv Chelation Therapy (Chemical Endarterectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
M0301	Fabric Wrapping Of Abdominal Aneurysm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
M1003	Tb Screening Performed And Results Interpreted Within Twelve Months Prior To Initiation Of First-Time Biologic And/Or Immune Response Modifier Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1004	Documentation Of Medical Reason For Not Screening For Tb Or Interpreting Results (I.E., Patient Positive For Tb And Documentation Of Past Treatment; Patient Who Has Recently Completed A Course Of Anti-Tb Therapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1005	Tb Screening Not Performed Or Results Not Interpreted, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1006	Disease Activity Not Assessed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1007	>=50% Of Total Number Of A Patient'S Outpatient Ra Encounters Assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1008	<50% Of Total Number Of A Patient'S Outpatient Ra Encounters Assessed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1009	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1010	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1011	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1012	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1013	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1014	Discharge/Discontinuation Of The Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1016	Female Patients Unable To Bear Children	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1018	Patients With An Active Diagnosis Or History Of Cancer (Except Basal Cell And Squamous Cell Skin Carcinoma), Patients Who Are Heavy Tobacco Smokers, Lung Cancer Screening Patients	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1019	Adolescent Patients 12 To 17 Years Of Age With Major Depression Or Dysthymia Who Reached Remission At Twelve Months As Demonstrated By A Twelve Month (+/-60 Days) Phq-9 Or Phq-9M Score Of Less Than 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1020	Adolescent Patients 12 To 17 Years Of Age With Major Depression Or Dysthymia Who Did Not Reach Remission At Twelve Months As Demonstrated By A Twelve Month (+/-60 Days) Phq-9 Or Phq-9M Score Of Less Than 5. Either Phq-9 Or Phq-9M Score Was Not Assessed Or Is Greater Than Or Equal To 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

M1021	Patient Had Only Urgent Care Visits During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1027	Imaging Of The Head (Ct Or Mri) Was Obtained	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1028	Documentation Of Patients With Primary Headache Diagnosis And Imaging Other Than Ct Or Mri Obtained	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1029	Imaging Of The Head (Ct Or Mri) Was Not Obtained, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1032	Adults Currently Taking Pharmacotherapy For Oud	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1034	Adults Who Have At Least 180 Days Of Continuous Pharmacotherapy With A Medication Prescribed For Oud Without A Gap Of More Than Seven Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1035	Adults Who Are Deliberately Phased Out Of Medication Assisted Treatment (Mat) Prior To 180 Days Of Continuous Treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1036	Adults Who Have Not Had At Least 180 Days Of Continuous Pharmacotherapy With A Medication Prescribed For Oud Without A Gap Of More Than Seven Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1037	Patients With A Diagnosis Of Lumbar Spine Region Cancer At The Time Of The Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1038	Patients With A Diagnosis Of Lumbar Spine Region Fracture At The Time Of The Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1039	Patients With A Diagnosis Of Lumbar Spine Region Infection At The Time Of The Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1040	Patients With A Diagnosis Of Lumbar Idiopathic Or Congenital Scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1041	Patient Had Cancer, Acute Fracture Or Infection Related To The Lumbar Spine Or Patient Had Neuromuscular, Idiopathic Or Congenital Lumbar Scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1043	Functional Status Was Not Measured By The Oswestry Disability Index (Odi Version 2.1A) At One Year (9 To 15 Months) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1045	Functional Status Measured By The Oxford Knee Score (Oks) At One Year (9 To 15 Months) Postoperatively Was Greater Than Or Equal To 37 Or Knee Injury And Osteoarthritis Outcome Score Joint Replacement (Koos, Jr.) Was Greater Than Or Equal To 71	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1046	Functional Status Measured By The Oxford Knee Score (Oks) At One Year (9 To 15 Months) Postoperatively Was Less Than 37 Or The Knee Injury And Osteoarthritis Outcome Score Joint Replacement (Koos, Jr.) Was Less Than 71 Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1049	Functional Status Was Not Measured By The Oswestry Disability Index (Odi Version 2.1A) At Three Months (6 - 20 Weeks) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1051	Patient Had Cancer, Acute Fracture Or Infection Related To The Lumbar Spine Or Patient Had Neuromuscular, Idiopathic Or Congenital Lumbar Scoliosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1052	Leg Pain Was Not Measured By The Visual Analog Scale (Vas) Or Numeric Pain Scale At One Year (9 To 15 Months) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1054	Patient Had Only Urgent Care Visits During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1055	Aspirin Or Another Antiplatelet Therapy Used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

M1056	Prescribed Anticoagulant Medication During The Performance Period, History Of Gi Bleeding, History Of Intracranial Bleeding, Bleeding Disorder And Specific Provider Documented Reasons: Allergy To Aspirin Or Anti-Platelets, Use Of Non-Steroidal Anti-Inflammatory Agents, Drug-Drug Interaction, Uncontrolled Hypertension > 180/110 Mmhg Or Gastroesophageal Reflux Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1057	Aspirin Or Another Antiplatelet Therapy Not Used, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1058	Patient Was A Permanent Nursing Home Resident At Any Time During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1059	Patient Was In Hospice Or Receiving Palliative Care At Any Time During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1060	Patient Died Prior To The End Of The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1067	Hospice Services For Patient Provided Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1068	Adults Who Are Not Ambulatory	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1069	Patient Screened For Future Fall Risk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1070	Patient Not Screened For Future Fall Risk, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
M1106	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1107	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1108	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1109	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1110	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1111	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1112	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1113	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1114	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

M1115	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1116	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1117	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1118	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1119	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1120	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1121	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1122	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1123	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1124	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1125	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1126	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1127	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1128	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1129	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1130	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999

M1131	Documentation Stating Patient Has A Diagnosis Of A Degenerative Neurological Condition Such As Als, Ms, Or Parkinson'S Diagnosed At Any Time Before Or During The Episode Of Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1132	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1133	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1134	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1135	The Start Of An Episode Of Care Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1141	Functional Status Was Not Measured By The Oxford Knee Score (Oks) Or The Knee Injury And Osteoarthritis Outcome Score Joint Replacement (Koos, Jr.) At One Year (9 To 15 Months) Postoperatively	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1142	Emergent Cases	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1143	Initiated Episode Of Rehabilitation Therapy, Medical, Or Chiropractic Care For Neck Impairment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
M1146	Ongoing Care Not Clinically Indicated Because The Patient Needed A Home Program Only, Referral To Another Provider Or Facility, Or Consultation Only, As Documented In The Medical Record	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
M1147	Ongoing Care Not Medically Possible Because The Patient Was Discharged Early Due To Specific Medical Events, Documented In The Medical Record, Such As The Patient Became Hospitalized Or Scheduled For Surgery	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
M1148	Ongoing Care Not Possible Because The Patient Self-Discharged Early (E.G., Financial Or Insurance Reasons, Transportation Problems, Or Reason Unknown)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
M1149	Patient Unable To Complete The Neck Fs Prom At Initial Evaluation And/Or Discharge Due To Blindness, Illiteracy, Severe Mental Incapacity Or Language Incompatibility, And An Adequate Proxy Is Not Available	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
M1150	Left Ventricular Ejection Fraction (Lvef) Less Than Or Equal To 40% Or Documentation Of Moderately Or Severely Depressed Left Ventricular Systolic Function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1151	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1152	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1153	Patient With Diagnosis Of Osteoporosis On Date Of Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1154	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1155	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine Any Time During Or Before The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

M1159	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1160	Patient Had Anaphylaxis Due To The Meningococcal Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1161	Patient Had Anaphylaxis Due To The Tetanus, Diphtheria Or Pertussis Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1162	Patient Had Encephalitis Due To The Tetanus, Diphtheria Or Pertussis Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1163	Patient Had Anaphylaxis Due To The Hpv Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1164	Patients With Dementia Any Time During The Patient'S History Through The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1165	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1166	Pathology Report For Tissue Specimens Produced From Wide Local Excisions Or Re-Excisions	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1167	In Hospice Or Using Hospice Services During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1168	Patient Received An Influenza Vaccine On Or Between July 1 Of The Year Prior To The Measurement Period And June 30 Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1169	Documentation Of Medical Reason(S) For Not Administering Influenza Vaccine (E.G., Prior Anaphylaxis Due To The Influenza Vaccine)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1170	Patient Did Not Receive An Influenza Vaccine On Or Between July 1 Of The Year Prior To The Measurement Period And June 30 Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1171	Patient Received At Least One Td Vaccine Or One Tdap Vaccine Between Nine Years Prior To The Encounter And The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1172	Documentation Of Medical Reason(S) For Not Administering Td Or Tdap Vaccine (E.G., Prior Anaphylaxis Due To The Td Or Tdap Vaccine Or History Of Encephalopathy Within Seven Days After A Previous Dose Of A Td-Containing Vaccine)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1173	Patient Did Not Receive At Least One Td Vaccine Or One Tdap Vaccine Between Nine Years Prior To The Encounter And The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1174	Patient Received At Least Two Doses Of The Herpes Zoster Recombinant Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th Birthday Before Or During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1175	Documentation Of Medical Reason(S) For Not Administering Zoster Vaccine (E.G., Prior Anaphylaxis Due To The Zoster Vaccine)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1176	Patient Did Not Receive At Least Two Doses Of The Herpes Zoster Recombinant Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th Birthday Before Or During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1177	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 60Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

M1178	Documentation Of Medical Reason(S) For Not Administering Pneumococcal Vaccine (E.G., Prior Anaphylaxis Due To The Pneumococcal Vaccine)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1179	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide Vaccine, On Or After Their 60Th Birthday And Before Or During Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1180	Patients On Immune Checkpoint Inhibitor Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1181	Grade 2 Or Above Diarrhea And/Or Grade 2 Or Above Colitis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1182	Patients Not Eligible Due To Pre-Existing Inflammatory Bowel Disease (Ibd) (E.G., Ulcerative Colitis, Crohn'S Disease)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1183	Documentation Of Immune Checkpoint Inhibitor Therapy Held And Corticosteroids Or Immunosuppressants Prescribed Or Administered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1184	Documentation Of Medical Reason(S) For Not Prescribing Or Administering Corticosteroid Or Immunosuppressant Treatment (E.G., Allergy, Intolerance, Infectious Etiology, Pancreatic Insufficiency, Hyperthyroidism, Prior Bowel Surgical Interventions, Celiac Disease, Receiving Other Medication, Awaiting Diagnostic Workup Results For Alternative Etiologies, Other Medical Reasons/Contraindication)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1185	Documentation Of Immune Checkpoint Inhibitor Therapy Not Held And/Or Corticosteroids Or Immunosuppressants Prescribed Or Administered Was Not Performed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1186	Patients Who Have An Order For Or Are Receiving Hospice Or Palliative Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1187	Patients With A Diagnosis Of End Stage Renal Disease (Esrd)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1188	Patients With A Diagnosis Of Chronic Kidney Disease (Ckd) Stage 5	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1189	Documentation Of A Kidney Health Evaluation Defined By An Estimated Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr) Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1190	Documentation Of A Kidney Health Evaluation Was Not Performed Or Defined By An Estimated Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1191	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1192	Patients With An Existing Diagnosis Of Squamous Cell Carcinoma Of The Esophagus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1193	Surgical Pathology Reports That Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry, Msi By Dna-Based Testing Status, Or Both	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1194	Documentation Of Medical Reason(S) Surgical Pathology Reports Did Not Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry, Msi By Dna-Based Testing Status, Or Both Tests Were Not Included (E.G., Patient Will Not Be Treated With Checkpoint Inhibitor Therapy, No Residual Carcinoma Is Present In The Sample [Tissue Exhausted Or Status Post Neoadjuvant Treatment], Insufficient Tumor For Testing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

M1195	Surgical Pathology Reports That Do Not Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry, Msi By Dna-Based Testing Status, Or Both, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1196	Initial (Index Visit) Numeric Rating Scale (Nrs), Visual Rating Scale (Vrs), Or Itchyquant Assessment Score Of Greater Than Or Equal To 4	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1197	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial (Index) Assessment Score To The Follow-Up Visit Score	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1198	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not Completed During The Follow-Up Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1199	Patients Receiving Rrt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1200	Ace Inhibitor (Ace-I) Or Arb Therapy Prescribed During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1201	Documentation Of Medical Reason(S) For Not Prescribing Ace Inhibitor (Ace-I) Or Arb Therapy During The Measurement Period (E.G., Pregnancy, History Of Angioedema To Ace-I, Other Allergy To Ace-I And Arb, Hyperkalemia Or History Of Hyperkalemia While On Ace-I Or Arb Therapy, Acute Kidney Injury Due To Ace-I Or Arb Therapy), Other Medical Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1202	Documentation Of Patient Reason(S) For Not Prescribing Ace Inhibitor Or Arb Therapy During The Measurement Period, (E.G., Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1203	Ace Inhibitor Or Arb Therapy Not Prescribed During The Measurement Period, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1204	Initial (Index Visit) Numeric Rating Scale (Nrs), Visual Rating Scale (Vrs), Or Itchyquant Assessment Score Of Greater Than Or Equal To 4	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1205	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial (Index) Assessment Score To The Follow-Up Visit Score	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1206	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not Completed During The Follow-Up Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1207	Patient Is Screened For Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, And Interpersonal Safety	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1208	Patient Is Not Screened For Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, And Interpersonal Safety	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1209	At Least Two Orders For High-Risk Medications From The Same Drug Class, (Table 4), Without Appropriate Diagnoses	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1210	At Least Two Orders For High-Risk Medications From The Same Drug Class, (Table 4), Not Ordered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1211	Most Recent Hemoglobin A1C Level > 9.0%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1212	Hemoglobin A1C Level Is Missing, Or Was Not Performed During The Measurement Period (12 Months)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1213	No History Of Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) And Present Spirometry Is >= 70%	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1214	Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) Documented And Reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1215	Documentation Of Medical Reason(S) For Not Documenting And Reviewing Spirometry Results (E.G., Patients With Dementia Or Tracheostomy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1216	No Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) Documented And/Or No Spirometry Performed With Results Documented During The Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1217	Documentation Of System Reason(S) For Not Documenting And Reviewing Spirometry Results (E.G., Spirometry Equipment Not Available At The Time Of The Encounter)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1218	Patient Has Copd Symptoms (E.G., Dyspnea, Cough/Sputum, Wheezing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1219	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1220	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; With Evidence Of Retinopathy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1221	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; Without Evidence Of Retinopathy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1222	Glaucoma Plan Of Care Not Documented, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1223	Glaucoma Plan Of Care Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1224	Intraocular Pressure (Iop) Reduced By A Value Less Than 20% From The Pre-Intervention Level	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1225	Intraocular Pressure (Iop) Reduced By A Value Of Greater Than Or Equal To 20% From The Pre-Intervention Level	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1226	Iop Measurement Not Documented, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1227	Evidence-Based Therapy Was Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1228	Patient, Who Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia, Has Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1229	Patient, Who Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia, Is Referred Within 1 Month Of The Reactive Hcv Antibody Test To A Clinician Who Treats Hcv Infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1230	Patient Has A Reactive Hcv Antibody Test And Does Not Have A Follow Up Hcv Viral Test, Or Patient Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Detects Hcv Viremia And Is Not Referred To A Clinician Who Treats Hcv Infection Within 1 Month And Does Not Have Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1231	Patient Receives Hcv Antibody Test With Nonreactive Result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1232	Patient Receives Hcv Antibody Test With Reactive Result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1233	Patient Does Not Receive Hcv Antibody Test Or Patient Does Receive Hcv Antibody Test But Results Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1234	Patient Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Does Not Detect Hcv Viremia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1235	Documentation Or Patient Report Of Hcv Antibody Test Or Hcv Rna Test Which Occurred Prior To The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1236	Baseline Mrs > 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1237	Patient Reason For Not Screening For Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, And Interpersonal Safety (E.G., Patient Declined Or Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1238	Documentation That Administration Of Second Recombinant Zoster Vaccine Could Not Occur During The Performance Period Due To The Recommended 2-6 Month Interval Between Doses (I.E, First Dose Received After October 31)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1239	Patient Did Not Respond To The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1240	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1241	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Saw Me As A Person, Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1242	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1243	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1244	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1245	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Saw Me As A Person, Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1246	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1247	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1248	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Saw Me As A Person, Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1249	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1250	Patient Responded As Completely True For The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1251	Patients For Whom A Proxy Completed The Entire Hu Survey On Their Behalf For Any Reason (No Patient Involvement)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1252	Patients Who Did Not Complete At Least One Of The Four Patient Experience Hu Survey Items And Return The Hu Survey Within 60 Days Of The Ambulatory Palliative Care Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1253	Patients Who Respond On The Patient Experience Hu Survey That They Did Not Receive Care By The Listed Ambulatory Palliative Care Provider In The Last 60 Days (Disavowal)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1254	Patients Who Were Deceased When The Hu Survey Reached Them	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1255	Patients Who Have Another Reason For Visiting The Clinic [Not Prenatal Or Postpartum Care] And Have A Positive Pregnancy Test But Have Not Established The Clinic As An Ob Provider (E.G., Plan To Terminate The Pregnancy Or Seek Prenatal Services Elsewhere)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1256	Prior History Of Known Cvd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1257	Cvd Risk Assessment Not Performed Or Incomplete (E.G., Cvd Risk Assessment Was Not Documented), Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1258	Cvd Risk Assessment Performed, Have A Documented Calculated Risk Score	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1259	Patients Listed On The Kidney-Pancreas Transplant Waitlist Or Who Received A Living Donor Transplant Within The First Year Following Initiation Of Dialysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1260	Patients Who Were Not Listed On The Kidney-Pancreas Transplant Waitlist Or Patients Who Did Not Receive A Living Donor Transplant Within The First Year Following Initiation Of Dialysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1261	Patients That Were On The Kidney Or Kidney-Pancreas Waitlist Prior To Initiation Of Dialysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1262	Patients Who Had A Transplant Prior To Initiation Of Dialysis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1263	Patients In Hospice On Their Initiation Of Dialysis Date Or During The Month Of Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1264	Patients Age 75 Or Older On Their Initiation Of Dialysis Date	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1265	Cms Medical Evidence Form 2728 For Dialysis Patients: Initial Form Completed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1266	Patients Admitted To A Skilled Nursing Facility (Snf)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1267	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist Or Is Not In Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1268	Patients On Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1269	Receiving Esrd Mcp Dialysis Services By The Provider On The Last Day Of The Reporting Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1270	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1271	Patients With Dementia At Any Time Prior To Or During The Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1272	Patients On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1273	Patients Who Were Admitted To A Skilled Nursing Facility (Snf) Within One Year Of Dialysis Initiation According To The Cms-2728 Form	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1274	Patients Who Were Admitted To A Skilled Nursing Facility (Snf) During The Month Of Evaluation Were Excluded From That Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1275	Patients Determined To Be In Hospice Were Excluded From Month Of Evaluation And The Remainder Of Reporting Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1276	Bmi Documented Outside Normal Parameters, No Follow-Up Plan Documented, No Reason Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1277	Colorectal Cancer Screening Results Documented And Reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1278	Elevated Or Hypertensive Blood Pressure Reading Documented, And The Indicated Follow-Up Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1279	Elevated Or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1280	Women Who Had A Bilateral Mastectomy Or Who Have A History Of A Bilateral Mastectomy Or For Whom There Is Evidence Of A Right And A Left Unilateral Mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1281	Blood Pressure Reading Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1282	Patient Screened For Tobacco Use And Identified As A Tobacco Non-User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1283	Patient Screened For Tobacco Use And Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1284	Patients Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long Term Care With Pos Code 32, 33, 34, 54, Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1285	Screening, Diagnostic, Film, Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Were Not Documented And Reviewed, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1286	Bmi Is Documented As Being Outside Of Normal Parameters, Follow-Up Plan Is Not Completed For Documented Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1287	Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1288	Documented Reason For Not Screening Or Recommending A Follow-Up For High Blood Pressure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1289	Patient Identified As Tobacco User Did Not Receive Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1290	Patient Not Eligible Due To Active Diagnosis Of Hypertension	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1291	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1292	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1293	Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1294	Normal Blood Pressure Reading Documented, Follow-Up Not Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1295	Patients With A Diagnosis Or Past History Of Total Colectomy Or Colorectal Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1296	Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is Required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1297	Bmi Not Documented Due To Medical Reason Or Patient Refusal Of Height Or Weight Measurement	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1298	Documentation Of Patient Pregnancy Anytime During The Measurement Period Prior To And Including The Current Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1299	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1300	Influenza Immunization Was Not Administered For Reasons Documented By Clinician (E.G., Patient Allergy Or Other Medical Reasons, Patient Declined Or Other Patient Reasons, Vaccine Not Available Or Other System Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1301	Patient Identified As A Tobacco User Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1302	Screening, Diagnostic, Film Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Documented And Reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1303	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1304	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1305	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1306	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine Any Time During Or Before The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1307	Documentation Stating The Patient Has Received Or Is Currently Receiving Palliative Or Hospice Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1308	Influenza Immunization Was Not Administered, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1309	Palliative Care Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1310	Patient Screened For Tobacco Use And Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling, Pharmacotherapy, Or Both), If Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1311	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1312	Patient Not Screened For Tobacco Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1313	Tobacco Screening Not Performed Or Tobacco Cessation Intervention Not Provided During The Measurement Period Or In The Six Months Prior To The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1314	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1315	Colorectal Cancer Screening Results Were Not Documented And Reviewed; Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1316	Current Tobacco Non-User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1317	Patients Who Are Counseled On Connection With A Csp And Explicitly Opt Out	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1318	Patients Who Did Not Have Documented Contact With A Csp For At Least One Of Their Screened Positive Hrsns Within 60 Days After Screening Or Documentation That There Was No Contact With A Csp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1319	Patients Who Had Documented Contact With A Csp For At Least One Of Their Screened Positive Hrsns Within 60 Days After Screening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1320	Patients Who Screened Positive For At Least 1 Of The 5 Hrsns	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1321	Patients Who Were Not Seen Within 7 Weeks Following The Date Of Injection For Follow Up Or Who Did Not Have A Documented Iop Or No Plan Of Care Documented If The Iop Was >25 Mm Hg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1322	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened For Elevated Intraocular Pressure (Iop) With Tonometry With Documented Iop =<25 Mm Hg For Injected Eye	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1323	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened For Elevated Intraocular Pressure (Iop) With Tonometry With Documented Iop >25 Mm Hg And A Plan Of Care Was Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1324	Patients Who Had An Intravitreal Or Periocular Corticosteroid Injection (E.G., Triamcinolone, Preservative-Free Triamcinolone, Dexamethasone, Dexamethasone Intravitreal Implant, Or Fluocinolone Intravitreal Implant)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1325	Patients Who Were Not Seen For Reasons Documented By Clinician For Patient Or Medical Reasons (E.G., Inadequate Time For Follow-Up, Patients Who Received A Prior Intravitreal Or Periocular Steroid Injection Within The Last Six (6) Months And Had A Subsequent Iop Evaluation With Iop <25Mm Hg Within Seven (7) Weeks Of Treatment)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1326	Patients With A Diagnosis Of Hypotony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1327	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or Who Were Not Re-Evaluated Within 8 Weeks	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1328	Patients With A Diagnosis Of Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1329	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within 2 Weeks Before The Initial Encounter Or 8 Weeks After Initial Acute Pvd Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1330	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G., Inadequate Time For Follow Up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1331	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-Evaluated No Later Than 8 Weeks From Initial Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1332	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or Who Were Not Re-Evaluated Within 2 Weeks	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1333	Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1334	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within 2 Weeks Before The Initial Encounter Or 2 Weeks After Initial Acute Pvd Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1335	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G., Inadequate Time For Follow Up)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1336	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-Evaluated No Later Than 2 Weeks	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1337	Acute Pvd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1338	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index Assessment Who Did Not Demonstrate Positive Improvement Or Maintenance Of Functioning Scores During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1339	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index Assessment Who Demonstrated Positive Improvement Or Maintenance Of Functioning Scores During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1340	Index Assessment Completed Using The 12-Item Whodas 2.0 Or Sds During The Denominator Identification Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1341	Patients Who Did Not Have A Follow-Up Assessment Or Did Not Have An Assessment Within 30 To 180 Days After The Index Assessment During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1342	Patients Who Died During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1343	Patients Who Are At Pam Level 4 At Baseline Or Patients Who Are Flagged With Extreme Straight Line Response Sets On The Pam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1344	Patients Who Did Not Have A Baseline Pam Score And/Or A Second Score Within 6 To 12 Month Of Baseline Pam Score	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1345	Patients Who Had A Baseline Pam Score And A Second Score Within 6 To 12 Month Of Baseline Pam Score	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1346	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 6 Points Within A 6 To 12 Month Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1347	Patients Who Achieved A Net Increase In Pam Score Of At Least 3 Points In A 6 To 12 Month Period (Passing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1348	Patients Who Achieved A Net Increase In Pam Score Of At Least 6-Points In A 6 To 12 Month Period (Excellent)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1349	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 3 Points Within 6 To 12 Month Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1350	Patients Who Had A Completed Suicide Safety Plan Initiated, Reviewed Or Updated In Collaboration With Their Clinician (Concurrent Or Within 24 Hours) Of The Index Clinical Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1351	Patients Who Had A Suicide Safety Plan Initiated, Reviewed, Or Updated And Reviewed And Updated In Collaboration With The Patient And Their Clinician Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After Initiation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1352	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs Or Equivalent Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1353	Patients Who Did Not Have A Completed Suicide Safety Plan Initiated, Reviewed Or Updated In Collaboration With Their Clinician (Concurrent Or Within 24 Hours) Of The Index Clinical Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1354	Patients Who Did Not Have A Suicide Safety Plan Initiated, Reviewed, Or Updated Or Reviewed And Updated In Collaboration With The Patient And Their Clinician Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After Initiation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1355	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1356	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1357	Patients Who Had A Reduction In Suicidal Ideation And/Or Behavior Upon Follow-Up Assessment Within 120 Days Of Index Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1358	Patients Who Did Not Have A Reduction In Suicidal Ideation And/Or Behavior Upon Follow-Up Assessment Within 120 Days Of Index Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1359	Index Assessment During The Denominator Period When The Suicidal Ideation And/Or Behavior Symptoms Or Increased Suicide Risk By Clinician Determination Occurs And A Non-Zero C-Ssrs Score Is Obtained	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1360	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1361	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1362	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1363	Patients Who Did Not Have A Follow-Up Assessment Within 120 Days Of The Index Assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1364	Calculated 10-Year Ascvd Risk Score Of >= 20 Percent During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1365	Patient Encounter During The Performance Period With Hospice And Palliative Care Specialty Code 17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1366	Focusing On Women'S Health Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1367	Quality Care For The Treatment Of Ear, Nose, And Throat Disorders Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1368	Prevention And Treatment Of Infectious Disorders Including Hepatitis C And Hiv Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1369	Quality Care In Mental Health And Substance Use Disorders Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1370	Rehabilitative Support For Musculoskeletal Care Mips Value Pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

P2031	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
P9020	Platelet Rich Plasma, Each Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
P9603	Travel Allowance One Way In Connection With Medically Necessary Laboratory Specimen Collection Drawn From Home Bound Or Nursing Home Bound Patient; Prorated Miles Actually Travelled	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
P9604	Travel Allowance One Way In Connection With Medically Necessary Laboratory Specimen Collection Drawn From Home Bound Or Nursing Home Bound Patient; Prorated Trip Charge.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
P9615	Catheterization For Collection Of Specimen (S) (Multiple Patients)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0092	Set-Up Portable X-Ray Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0224	Injection, Pemivibart, For The Pre-Exposure Prophylaxis Only, For Certain Adults And Adolescents (12 Years Of Age And Older Weighing At Least 40 Kg) With No Known Sars-Cov-2 Exposure, And Who Either Have Moderate-To-Severe Immune Compromise Due To A Medical Condition Or Receipt Of Immunosuppressive Medications Or Treatments, And Are Unlikely To Mount An Adequate Immune Response To Covid-19 Vaccination, 4500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/22/2024	12/31/2999
Q0240	Injection, Casirivimab And Imdevimab, 600 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0243	Injection, Casirivimab And Imdevimab, 2400 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0244	Injection, Casirivimab And Imdevimab, 1200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0245	Injection, Bamlanivimab And Etesevimab, 2100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
Q0477	Power Module Patient Cable For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
Q0478	Power Adapter For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Vehicle Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0479	Power Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0480	Driver For Use With Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0481	Microprocessor Control Unit For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

Q0482	Microprocessor Control Unit For Use With Electric/Pneumatic Combination Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0483	Monitor/Display Module For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0484	Monitor/Display Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0485	Monitor Control Cable For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0486	Monitor Control Cable For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0487	Leads (Pneumatic/Electrical) For Use With Any Type Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0488	Power Pack Base For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0489	Power Pack Base For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0490	Emergency Power Source For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0491	Emergency Power Source For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0492	Emergency Power Supply Cable For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0493	Emergency Power Supply Cable For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0494	Emergency Hand Pump For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0495	Battery/Power Pack Charger For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0496	Battery, Other Than Lithium-Ion, For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0497	Battery Clips For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

Q0498	Holster For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0499	Belt/Vest/Bag For Use To Carry External Peripheral Components Of Any Type Ventricular Assist Device, Replacement Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0500	Filters For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0501	Shower Cover For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
Q0502	Mobility Cart For Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0503	Battery For Pneumatic Ventricular Assist Device, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0504	Power Adapter For Pneumatic Ventricular Assist Device, Replacement Only, Vehicle Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0506	Battery, Lithium-Ion, For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0507	Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2013	12/31/2999
Q0508	Miscellaneous Supply Or Accessory For Use With An Implanted Ventricular Assist Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2013	12/31/2999
Q0509	Miscellaneous Supply Or Accessory For Use With Any Implanted Ventricular Assist Device For Which Payment Was Not Made Under Medicare Part A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2013	12/31/2999
Q0510	Pharmacy Supply Fee For Initial Immunosuppressive Drug(S), First Month Following Transplant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0511	Pharmacy Supply Fee For Oral Anti-Cancer, Oral Anti-Emetic Or Immunosuppressive Drug(S); For The First Prescription In A 30-Day Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0512	Pharmacy Supply Fee For Oral Anti-Cancer, Oral Anti-Emetic Or Immunosuppressive Drug(S); For A Subsequent Prescription In A 30-Day Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/16/2016	12/31/2999
Q0513	Pharmacy Dispensing Fee For Inhalation Drug(S); Per 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0514	Pharmacy Dispensing Fee For Inhalation Drug(S); Per 90 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
Q0515	Injection, Sermorelin Acetate, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q0516	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Oral Drug, Per 30-Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999

Q0517	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Oral Drug, Per 60-Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999
Q0518	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Oral Drug, Per 90-Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999
Q2026	Injection, Radiesse, 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q2028	Injection, Sculptra, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
Q2041	Axicabtagene Ciloleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2018	12/31/2999
Q2042	Tisagenlecleucel, Up To 600 Million Car-Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
Q2052	Services, Supplies, And Accessories Used In The Home For The Administration Of Intravenous Immune Globulin (Ivig)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2014	12/31/2999
Q2053	Brexucabtagene Autoleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
Q2054	Lisocabtagene Maraleucel, Up To 110 Million Autologous Anti-Cd19 Car-Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
Q2055	Idecabtagene Vicleucel, Up To 510 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
Q2056	Ciltacabtagene Autoleucel, Up To 100 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
Q3014	Telehealth Originating Site Facility Fee	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
Q4100	Skin Substitute, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4101	Apligraf, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4102	Oasis Wound Matrix, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4103	Oasis Burn Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Q4104	Integra Bilayer Matrix Wound Dressing (Bmwd), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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.	8/1/2019	12/31/2999
Q4106	Dermagraft, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4107	Graftjacket, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4108	Integra Matrix, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4110	Primatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4111	Gammagraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4112	Cymetra, Injectable, 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4113	Graftjacket Xpress, Injectable, 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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.	8/1/2019	12/31/2999
Q4115	Alloskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4116	Alloderm, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2019	12/31/2999
Q4117	Hyalomatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4118	Matristem Micromatrix, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4121	Theraskin, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q4122	Dermacell, Dermacell Awm Or Dermacell Awm Porous, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2021	12/31/2999

Q4123	Alloskin Rt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4124	Oasis Ultra Tri-Layer Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4125	Arthroflex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4126	Memoderm, Dermaspan, Tranzgraft Or Integuply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4127	Talymed, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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.	8/1/2019	12/31/2999
Q4130	Strattice Tm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4132	Grafix Core And Grafixpl Core, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4133	Grafix Prime, Grafixpl Prime, Stravix And Stravixpl, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4134	Hmatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4135	Mediskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4136	Ez-Derm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4137	Amnioexcel, Amnioexcel Plus Or Biodexcel, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
Q4138	Biodfence Dryflex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4139	Amniomatrix Or Biodmatrix, Injectable, 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4140	Biodfence, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4141	Alloskin Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4142	Xcm Biologic Tissue Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4143	Repriza, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4145	Epifix, Injectable, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4146	Tensix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4147	Architect, Architect Px, Or Architect Fx, Extracellular Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4148	Neox Cord 1K, Neox Cord Rt, Or Clarix Cord 1K, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4149	Excellagen, 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4150	Allowrap Ds Or Dry, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4151	Amnioband Or Guardian, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4152	Dermapure, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4153	Dermavest And Plurivest, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4154	Biovance, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4155	Neoxflo Or Clarixflo, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4156	Neox 100 Or Clarix 100, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4157	Revitalon, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4158	Kerecis Omega3, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4159	Affinity, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
Q4160	Nushield, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4161	Bio-Connekt Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4162	Woundex Flow, Bioskin Flow, 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4163	Woundex, Bioskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4164	Helicoll, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4165	Keramatrix Or Kerasorb, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4166	Cytal, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4167	Truskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4168	Amnioband, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4169	Artacent Wound, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4170	Cygnus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4171	Interfyl, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4173	Palingen Or Palingen Xplus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4174	Palingen Or Promatrx, 0.36 Mg Per 0.25 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4175	Miroderm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
Q4176	Neopatch Or Therion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4177	Floweramnioflo, 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4178	Floweramniopatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4179	Flowerderm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4180	Revita, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4181	Amnio Wound, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4182	Transcyte, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4183	Surgigraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4184	Cellesta Or Cellesta Duo, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4185	Cellesta Flowable Amnion (25 Mg Per Cc); Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4186	Epifix, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
Q4187	Epicord, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
Q4188	Amnioarmor, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4189	Artacent Ac, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4190	Artacent Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4191	Restorigin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4192	Restorigin, 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4193	Coll-E-Derm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4194	Novachor, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4195	Puraply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4196	Puraply Am, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4197	Puraply Xt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4198	Genesis Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4199	Cygnus Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4200	Skin Te, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4201	Matrion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4202	Keroxx (2.5G/Cc), 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4203	Derma-Gide, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4204	Xwrap, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4205	Membrane Graft Or Membrane Wrap, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4206	Fluid Flow Or Fluid Gf, 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4208	Novafix, Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4209	Surgraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4211	Amnion Bio Or Axobiomembrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4212	Allogen, Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4213	Ascent, 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4214	Cellesta Cord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4215	Axolotl Ambient Or Axolotl Cryo, 0.1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4216	Artacent Cord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4217	Woundfix, Biowound, Woundfix Plus, Biowound Plus, Woundfix Xplus Or Biowound Xplus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4218	Surgicord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4219	Surgigraft-Dual, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4220	Bellacell Hd Or Surederm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4221	Amniowrap2, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4222	Progenamatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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).	4/1/2022	12/31/2999
Q4225	Amniobind Or Dermabind Tl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999

Q4226	Myown Skin, Includes Harvesting And Preparation Procedures, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
Q4227	Amniocore, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4229	Cogenex Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4230	Cogenex Flowable Amnion, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4231	Corplex P, Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4232	Corplex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4233	Surfactor Or Nudyn, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4234	Xcellerate, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4235	Amniorepair Or Altiply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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).	3/1/2024	12/31/2999
Q4237	Cryo-Cord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4238	Derm-Maxx, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2022	12/31/2999
Q4239	Amnio-Maxx Or Amnio-Maxx Lite, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4240	Corecyte, For Topical Use Only, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4241	Polycyte, For Topical Use Only, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4242	Amniocyte Plus, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Q4245	Amniotext, Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4246	Coretext Or Protext, Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4247	Amniotext Patch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4248	Dermacyte Amniotic Membrane Allograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4249	Amniply, For Topical Use Only, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4250	Amnioamp-Mp, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4251	Vim, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4252	Vendaje, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4253	Zenith Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4254	Novafix Dl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4255	Reguard, For Topical Use Only, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4256	Mlg-Complete, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4257	Relese, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4258	Enverse, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
Q4259	Celera Dual Layer Or Celera Dual Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4260	Signature Apatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999

Q4261	Tag, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4262	Dual Layer Impax Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4263	Surgraft Tl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4264	Cocoon Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4265	Neostim Tl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4266	Neostim Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4267	Neostim Dl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4268	Surgraft Ft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4269	Surgraft Xt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4270	Complete Sl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4271	Complete Ft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4272	Esano A, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4273	Esano Aaa, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4274	Esano Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4275	Esano Aca, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4276	Orion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999

Q4278	Epieffect, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4279	Vendaje Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4280	Xcell Amnio Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4281	Barrera Sl Or Barrera Dl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4282	Cygnus Dual, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4283	Biovance Tri-Layer Or Biovance 3L, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
Q4284	Dermabind Sl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4285	Nudyn Dl Or Nudyn Dl Mesh, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4286	Nudyn Sl Or Nudyn Slw, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4287	Dermabind Dl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4288	Dermabind Ch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4289	Revoshield + Amniotic Barrier, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4290	Membrane Wrap-Hydro, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4291	Lamellas Xt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4292	Lamellas, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4293	Acesso Dl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4294	Amnio Quad-Core, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4295	Amnio Tri-Core Amniotic, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4296	Rebound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4297	Emerge Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4298	Amnicore Pro, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4299	Amnicore Pro+, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4300	Acesso Tl, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4301	Activate Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4302	Complete Aca, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4303	Complete Aa, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
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.	1/1/2024	12/31/2999
Q4305	American Amnion Ac Tri-Layer, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4306	American Amnion Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4307	American Amnion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4308	Sanopellis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4309	Via Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999

Q4310	Procenta, Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4311	Acesso, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4312	Acesso Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4313	Dermabind Fm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4314	Reeva Ft, Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4315	Regenelink Amniotic Membrane Allograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4316	Amchoplast, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4317	Vitograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4318	E-Graft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4319	Sanograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4320	Pellograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4321	Renograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4322	Caregraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4323	Alloply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4324	Amniotx, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4325	Acapatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Q4326	Woundplus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4327	Duoamnion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4328	Most, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4329	Singlay, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4330	Total, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4331	Axolotl Graft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4332	Axolotl Dualgraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4333	Ardeograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q5010	Hospice Home Care Provided In A Hospice Facility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
Q5101	Injection, Filgrastim-Sndz, Biosimilar, (Zarxio), 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
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.	12/1/2019	12/31/2999
Q5108	Injection, Pegfilgrastim-Jmdb (Fulphila), Biosimilar, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
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.	1/1/2019	12/31/2999
Q5110	Injection, Filgrastim-Aafi, Biosimilar, (Nivestym), 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
Q5120	Injection, Pegfilgrastim-Bmez (Ziextenzo), Biosimilar, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
Q5122	Injection, Pegfilgrastim-Apgf (Nyvepria), Biosimilar, 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999

Q5124	Injection, Ranibizumab-Nuna, Biosimilar, (Byooviz), 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
Q5128	Injection, Ranibizumab-Eqrn (Cimerli), Biosimilar, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
Q5133	Injection, Tocilizumab-Bavi (Tofidence), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
Q5134	Injection, Natalizumab-Sztn (Tyruko), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
Q5137	Injection, Ustekinumab-Auub (Wezlana), Biosimilar, Subcutaneous, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q5138	Injection, Ustekinumab-Auub (Wezlana), Biosimilar, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q9001	Assessment By Chaplain Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
Q9002	Counseling, Individual, By Chaplain Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
Q9003	Counseling, Group, By Chaplain Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
Q9004	Department Of Veterans Affairs Whole Health Partner Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2021	12/31/2999
Q9969	Tc-99M From Non-Highly Enriched Uranium Source, Full Cost Recovery Add-On, Per Study Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
R0070	Transportation Of Portable X-Ray Equipment And Personnel To Home Or Nursing Home, Per Trip To Facility Or Location, One Patient Seen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
R0075	Transportation Of Portable X-Ray Equipment And Personnel To Home Or Nursing Home, Per Trip To Facility Or Location, More Than One Patient Seen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
R0076	Transportation Of Portable Ekg To Facility Or Location, Per Patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0013	Esketamine, Nasal Spray, 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
S0126	Injection, Follitropin Alfa, 75 Iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0128	Injection, Follitropin Beta, 75 Iu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0132	Injection, Ganirelix Acetate, 250 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
S0155	Sterile Dilutant For Epoprostenol, 50Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S0189	Testosterone Pellet, 75Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
S0197	Prenatal Vitamins, 30-Day Supply	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0207	Paramedic Intercept, Non-Hospital-Based Als Service (Non-Voluntary), Non-Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
S0208	Paramedic Intercept, Hospital-Based Als Service (Non-Voluntary), Non-Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
S0209	Wheelchair Van, Mileage, Per Mile	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
S0215	Non-Emergency Transportation; Mileage, Per Mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S0260	History And Physical (Outpatient Or Office) Related To Surgical Procedure (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.	1/1/2013	12/31/2999
S0271	Physician Management Of Patient Home Care, Hospice Monthly Case Rate (Per 30 Days)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0302	Completed Early Periodic Screening Diagnosis And Treatment (Epsdt) Service (List 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.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S0340	Lifestyle Modification Program For Management Of Coronary Artery Disease, Including All Supportive Services; First Quarter / Stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0341	Lifestyle Modification Program For Management Of Coronary Artery Disease, Including All Supportive Services; Second Or Third Quarter / Stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0342	Lifestyle Modification Program For Management Of Coronary Artery Disease, Including All Supportive Services; Fourth Quarter / Stage	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S0390	Routine Foot Care; Removal And/Or Trimming Of Corns, Calluses And/Or Nails And Preventive Maintenance In Specific Medical Conditions (E. G. Diabetes), Per Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S0395	Impression Casting Of A Foot Performed By A Practitioner Other Than The Manufacturer Of The Orthotic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
S0510	Non-Prescription Lens (Safety, Athletic, Or Sunglass), Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S0516	Safety Eyeglass Frames	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S0518	Sunglasses Frames	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S0596	Phakic Intraocular Lens For Correction Of Refractive Error	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S0800	Laser In Situ Keratomileusis (Lasik)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

S0810	Photorefractive Keratectomy (Prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
S0812	Phototherapeutic Keratectomy (Ptk)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S1001	Deluxe Item, Patient Aware (List In Addition To Code For Basic Item)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S1030	Continuous Noninvasive Glucose Monitoring Device, Purchase (For Physician Interpretation Of Data, Use Cpt Code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S1031	Continuous Noninvasive Glucose Monitoring Device, Rental, Including Sensor, Sensor Replacement, And Download To Monitor (For Physician Interpretation Of Data, Use Cpt Code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S1034	Artificial Pancreas Device System (Eg, Low Glucose Suspend [Lgs] Feature) Including Continuous Glucose Monitor, Blood Glucose Device, Insulin Pump And Computer Algorithm That Communicates With All Of The Devices	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1035	Sensor; Invasive (Eg, Subcutaneous), Disposable, For Use With Artificial Pancreas Device System, 1 Unit = 1 Day Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1036	Transmitter; External, For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1037	Receiver (Monitor); External, For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1040	Cranial Remolding Orthosis, Pediatric, Rigid, With Soft Interface Material, Custom Fabricated, Includes Fitting And Adjustment(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	4/1/2021	12/31/2999
S2053	Transplantation Of Small Intestine And Liver Allografts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
S2054	Transplantation Of Multivisceral Organs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
S2055	Harvesting Of Donor Multivisceral Organs, With Preparation And Maintenance Of Allografts; From Cadaver Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
S2060	Lobar Lung Transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2061	Donor Lobectomy (Lung) For Transplantation, Living Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2065	Simultaneous Pancreas Kidney Transplantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S2066	Breast Reconstruction With Gluteal Artery Perforator (Gap) Flap, Including Harvesting Of The Flap, Microvascular Transfer, Closure Of Donor Site And Shaping The Flap Into A Breast, Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2024	12/31/2999
S2067	Breast Reconstruction Of A Single Breast With "Stacked" Depp Inferior Epigastric Perforator (Diep) Flap(S) And/Or Gluteal Artery Perforator (Gap) Flap(S), Including Harvesting Of The Flap(S), Microvascular Transfer, Closure Of Donor Site(S) And Shaping Th	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2024	12/31/2999
S2068	Breast Reconstruction With Deep Inferior Epigastric Perforator (Diep) Flap Or Superficial Inferior Epigastric Artery (Siea) Flap, Including Harvesting Of The Flap, Microvascular Transfer, Closure Of Donor Site And Shaping The Flap Into A Breast, Unilatera	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2024	12/31/2999
S2080	Laser-Assisted Uvulopalatoplasty (Laup)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S2095	Transcatheter Occlusion Or Embolization For Tumor Destruction, Percutaneous, Any Method, Using Yttrium-90 Microspheres	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2102	Islet Cell Tissue Transplant From Pancreas; Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S2103	Adrenal Tissue Transplant To Brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
S2107	Adoptive Immunotherapy I. E. Development Of Specific Anti-Tumor Reactivity (E. G. Tumor-Infiltrating Lymphocyte Therapy) Per Course Of Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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.	1/1/2013	12/31/2999
S2117	Arthroereisis, Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2118	Metal-On-Metal Total Hip Resurfacing, Including Acetabular And Femoral Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S2140	Cord Blood Harvesting For Transplantation, Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2142	Cord Blood-Derived Stem-Cell Transplantation, Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S2150	Bone Marrow Or Blood-Derived Stem Cells (Peripheral Or Umbilical), Allogeneic Or Autologous, Harvesting, Transplantation, And Related Complications; Including: Pheresis And Cell Preparation/Storage; Marrow Ablative Therapy; Drugs, Supplies, Hospitalization With Outpatient Follow-Up; Medical/Surgical, Diagnostic, Emergency, And Rehabilitative Services; And The Number Of Days Of Pre-And Post-Transplant Care In The Global Definition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2152	Solid Organ(S), Complete Or Segmental, Single Organ Or Combination Of Organs; Deceased Or Living Donor (S), Procurement, Transplantation, And Related Complications; Including: 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.	9/1/2016	12/31/2999
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2230	Implantation Of Magnetic Component Of Semi-Implantable Hearing Device On Ossicles In Middle Ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S2300	Arthroscopy, Shoulder, Surgical; With Thermally-Induced Capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2348	Decompression Procedure, Percutaneous, Of Nucleus Pulposus Of Intervertebral Disc, Using Radiofrequency Energy, Single Or Multiple Levels, Lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2020	12/31/2999
S2400	Repair, Congenital Diaphragmatic Hernia In The Fetus Using Temporary Tracheal Occlusion, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S2401	Repair, Urinary Tract Obstruction In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2402	Repair, Congenital Cystic Adenomatoid Malformation In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2403	Repair, Extralobar Pulmonary Sequestration In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2404	Repair, Myelomeningocele In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2405	Repair Of Sacrococcygeal Teratoma In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S2409	Repair, Congenital Malformation Of Fetus, Procedure Performed In Utero, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S2411	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin Transfusion Syndrome	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2020	12/31/2999
S3601	Emergency Stat Laboratory Charge For Patient Who Is Homebound Or Residing In A Nursing Facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S3650	Saliva Test, Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S3652	Saliva Test, Hormone Level; To Assess Preterm Labor Risk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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).	2/15/2015	12/31/2999
S4011	In Vitro Fertilization; Including But Not Limited To Identification And Incubation Of Mature Oocytes, Fertilization With Sperm, Incubation Of Embryo(S), And Subsequent Visualization For Determination Of Development	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4013	Complete Cycle, Gamete Intrafallopian Transfer (Gift), Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4014	Complete Cycle, Zygote Intrafallopian Transfer (Zift), Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4015	Complete In Vitro Fertilization Cycle, Not Otherwise Specified, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4016	Frozen In Vitro Fertilization Cycle, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4017	Incomplete Cycle, Treatment Cancelled Prior To Stimulation, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4018	Frozen Embryo Transfer Procedure Cancelled Before Transfer, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4020	In Vitro Fertilization Procedure Cancelled Before Aspiration, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4021	In Vitro Fertilization Procedure Cancelled After Aspiration, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4022	Assisted Oocyte Fertilization, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4023	Donor Egg Cycle, Incomplete, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4025	Donor Services For In Vitro Fertilization (Sperm Or Embryo), Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4026	Procurement Of Donor Sperm From Sperm Bank	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4027	Storage Of Previously Frozen Embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4028	Microsurgical Epididymal Sperm Aspiration (Mesa)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4030	Sperm Procurement And Cryopreservation Services; Initial Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4031	Sperm Procurement And Cryopreservation Services; Subsequent Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999

S4037	Cryopreserved Embryo Transfer, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4040	Monitoring And Storage Of Cryopreserved Embryos, Per 30 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999
S4042	Management Of Ovulation Induction (Interpretation Of Diagnostic Tests And Studies, Non-Face-To-Face Medical Management Of The Patient), Per Cycle	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S4988	Penile Contracture Device, Manual, Greater Than 3 Lbs Traction Force	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
S4990	Nicotine Patches, Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S4991	Nicotine Patches, Non-Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S5100	Day Care Services, Adult; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5101	Day Care Services, Adult; Per Half Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5102	Day Care Services, Adult; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5105	Day Care Services, Center-Based; Services Not Included In Program Fee, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5108	Home Care Training To Home Care Client, Per 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
S5110	Home Care Training, Family; Per 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
S5111	Home Care Training, Family; Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
S5120	Chore Services; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5121	Chore Services; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5130	Homemaker Service, Nos; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5131	Homemaker Service, Nos; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5135	Companion Care, Adult (E. G. Iadl/Adl); Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5136	Companion Care, Adult (E. G. Iadl/Adl); Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5140	Foster Care, Adult; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5141	Foster Care, Adult; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5145	Foster Care, Therapeutic, Child; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

S5146	Foster Care, Therapeutic, Child; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5162	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
S5165	Home Modifications; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S5170	Home Delivered Meals, Including Preparation; Per Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5175	Laundry Service, External, Professional; Per Order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S5199	Personal Care Item, Nos, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S8040	Topographic Brain Mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S8130	Interferential Current Stimulator, 2 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
S8131	Interferential Current Stimulator, 4 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
S8185	Flutter Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S8301	Infection Control Supplies, Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S8940	Equestrian/Hippotherapy, Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
S8948	Application Of A Modality (Requiring Constant Provider Attendance) To One Or More Areas; Low-Level Laser; Each 15 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2016	12/31/2999
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.	1/1/2020	12/31/2999
S9001	Home Uterine Monitor With Or Without Associated Nursing Services	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
S9002	Intra-Vaginal Motion Sensor System, Provides Biofeedback For Pelvic Floor Muscle Rehabilitation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
S9024	Paranasal Sinus Ultrasound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

S9055	Procuren Or Other Growth Factor Preparation To Promote Wound Healing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S9090	Vertebral Axial Decompression, Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2015	12/31/2999
S9117	Back School, Per Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S9122	Home Health Aide Or Certified Nurse Assistant, Providing Care In The Home; Per Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
S9123	Nursing Care, In The Home; By Registered Nurse, Per Hour (Use For General Nursing Care Only, Not To Be Used When Cpt Codes 99500-99602 Can Be Used)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
S9124	Nursing Care, In The Home; By Licensed Practical Nurse, Per Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
S9128	Speech Therapy, In The Home, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9129	Occupational Therapy, In The Home, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
S9131	Physical Therapy; In The Home, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
S9145	Insulin Pump Initiation, Instruction In Initial Use Of Pump (Pump Not Included)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
S9208	Home Management Of Preterm Labor, Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies Or Equipment (Drugs And Nursing Visits Coded Separately), Per Diem (Do Not Use This Code With Any Home Infusion Per Diem Code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2016	12/31/2999
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.	1/1/2013	12/31/2999
S9340	Home Therapy; Enteral Nutrition; Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9341	Home Therapy; Enteral Nutrition Via Gravity; Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S9342	Home Therapy; Enteral Nutrition Via Pump; Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9343	Home Therapy; Enteral Nutrition Via Bolus; Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9355	Home Infusion Therapy, Chelation Therapy; Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9364	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded Separately), Per Diem (Do Not Use With Home Infusion Codes S9365-S9368 Using Daily Volume Scales)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9365	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); One Liter Per Day, Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9366	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than One Liter But No More Than Two Liters Per Day, Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9367	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than Two Liters But No More Than Three Liters Per Day, Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9368	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than Three Liters Per Day, Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
S9430	Pharmacy Compounding And Dispensing Services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
S9432	Medical Foods For Non-Inborn Errors Of Metabolism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999

S9433	Medical Food Nutritionally Complete, Administered Orally, Providing 100% Of Nutritional Intake	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9449	Weight Management Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S9537	Home Therapy; Hematopoietic Hormone Injection Therapy (E. G. Erythropoietin, G-Csf, Gm-Csf); Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9558	Home Injectable Therapy; Growth Hormone, Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9560	Home Injectable Therapy; Hormonal Therapy (E. G. ; Leuprolide, Goserelin), Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
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.	1/1/2013	12/31/2999
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)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9960	Ambulance Service, Conventional Air Services, Nonemergency Transport, One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9961	Ambulance Service, Conventional Air Service, Nonemergency Transport, One Way (Rotary Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9975	Transplant Related Lodging, Meals And Transportation, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/1/2015	12/31/2999
S9976	Lodging, Per Diem, Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
S9977	Meals, Per Diem, Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
S9988	Services Provided As Part Of A Phase I Clinical Trial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9990	Services Provided As Part Of A Phase Ii Clinical Trial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

S9991	Services Provided As Part Of A Phase Iii Clinical Trial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9992	Transportation Costs To And From Trial Location And Local Transportation Costs (E. G. , Fares For Taxicab Or Bus) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S9994	Lodging Costs (E. G. , Hotel Charges) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S9996	Meals For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
S9999	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
T1000	Private Duty / Independent Nursing Service(S) - Licensed, Up To 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
T1014	Telehealth Transmission, Per Minute, Professional Services Bill Separately	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
T1030	Nursing Care, In The Home, By Registered Nurse, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
T1031	Nursing Care, In The Home, By Licensed Practical Nurse, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
T1032	Services Performed By A Doula Birth Worker, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2022	12/31/2999
T1033	Services Performed By A Doula Birth Worker, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2022	12/31/2999
T1040	Medicaid Certified Community Behavioral Health Clinic Services, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T1041	Medicaid Certified Community Behavioral Health Clinic Services, Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T2012	Habilitation, Educational; Waiver, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2013	Habilitation, Educational, Waiver; Per Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2014	Habilitation, Prevocational, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2015	Habilitation, Prevocational, Waiver; Per Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2016	Habilitation, Residential, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2017	Habilitation, Residential, Waiver; 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2018	Habilitation, Supported Employment, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2019	Habilitation, Supported Employment, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2020	Day Habilitation, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2021	Day Habilitation, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

T2026	Specialized Childcare, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2027	Specialized Childcare, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2030	Assisted Living, Waiver; Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2031	Assisted Living; Waiver, Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2035	Utility Services To Support Medical Equipment And Assistive Technology/Devices, Waiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2036	Therapeutic Camping, Overnight, Waiver; Each Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2037	Therapeutic Camping, Day, Waiver; Each Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2038	Community Transition, Waiver; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2039	Vehicle Modifications, Waiver; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2040	Financial Management, Self-Directed, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2041	Supports Brokerage, Self-Directed, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
T2047	Habilitation, Prevocational, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2020	12/31/2999
T2050	Financial Management, Self-Directed, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2022	12/31/2999
T2051	Supports Brokerage, Self-Directed, Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2022	12/31/2999
T2101	Human Breast Milk Processing, Storage And Distribution Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2/1/2020	12/31/2999
T4536	Incontinence Product, Protective Underwear/Pull-On, Reusable, Any Size, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4537	Incontinence Product, Protective Underpad, Reusable, Bed Size, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4538	Diaper Service, Reusable Diaper, Each Diaper	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4539	Incontinence Product, Diaper/Brief, Reusable, Any Size, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4540	Incontinence Product, Protective Underpad, Reusable, Chair Size, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4541	Incontinence Product, Disposable Underpad, Large, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4542	Incontinence Product, Disposable Underpad, Small Size, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4543	Adult Sized Disposable Incontinence Product, Protective Brief/Diaper, Above Extra Large, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2017	12/31/2999
T4544	Adult Sized Disposable Incontinence Product, Protective Underwear/Pull-On, Above Extra Large, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2014	12/31/2999
T4545	Incontinence Product, Disposable, Penile Wrap, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999

V2025	Deluxe Frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
V2523	Contact Lens, Hydrophilic, Extended Wear, Per Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
V2524	Contact Lens, Hydrophilic, Spherical, Photochromic Additive, Per Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
V2526	Contact Lens, Hydrophilic, With Blue-Violet Filter, Per Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
V2530	Contact Lens, Scleral, Gas Impermeable, Per Lens (For Contact Lens Modification, See 92325)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens (For Contact Lens Modification, See 92325)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2015	12/31/2999
V2600	Hand Held Low Vision Aids And Other Nonspectacle Mounted Aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2627	Scleral Cover Shell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2018	12/31/2999
V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
V2744	Tint, Photochromatic, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2745	Addition To Lens; Tint, Any Color, Solid, Gradient Or Equal, Excludes Photochromatic, Any Lens Material, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2750	Anti-Reflective Coating, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
V2755	U-V Lens, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2018	12/31/2999
V2756	Eye Glass Case	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2760	Scratch Resistant Coating, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2761	Mirror Coating, Any Type, Solid, Gradient Or Equal, Any Lens Material, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2762	Polarization, Any Lens Material, Per Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
V2787	Astigmatism Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
V2788	Presbyopia Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
V2790	Amniotic Membrane For Surgical Reconstruction, Per Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2020	12/31/2999

V2799	Vision Item Or Service, Miscellaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2018	12/31/2999
V5011	Fitting/Orientation/Checking Of Hearing Aid	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
V5095	Semi-Implantable Middle Ear Hearing Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
V5268	Assistive Listening Device, Telephone Amplifier, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5269	Assistive Listening Device, Alerting, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2015	12/31/2999
V5271	Assistive Listening Device, Television Caption Decoder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2015	12/31/2999
V5272	Assistive Listening Device, Tdd	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2015	12/31/2999
V5273	Assistive Listening Device, For Use With Cochlear Implant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2015	12/31/2999
V5274	Assistive Listening Device, Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2015	12/31/2999
V5281	Assistive Listening Device, Personal Fm/Dm System, Monaural, (1 Receiver, Transmitter, Microphone), Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5282	Assistive Listening Device, Personal Fm/Dm System, Binaural, (2 Receivers, Transmitter, Microphone), Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5283	Assistive Listening Device, Personal Fm/Dm Neck, Loop Induction Receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5284	Assistive Listening Device, Personal Fm/Dm, Ear Level Receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5285	Assistive Listening Device, Personal Fm/Dm, Direct Audio Input Receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5286	Assistive Listening Device, Personal Blue Tooth Fm/Dm Receiver	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5288	Assistive Listening Device, Personal Fm/Dm Transmitter Assistive Listening Device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5289	Assistive Listening Device, Personal Fm/Dm Adapter/Boot Coupling Device For Receiver, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5290	Assistive Listening Device, Transmitter Microphone, Any Type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
V5336	Repair/Modification Of Augmentative Communicative System Or Device (Excludes Adaptive Hearing Aid)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999

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 Montana. For other services/members, BCBSMT 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 BCBSMT members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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