

Medical Prior Authorization | Arkansas State Police

January 1, 2027

- Inpatient Admissions Facility Charges ONLY (Ancillary charges do NOT require PA)
- Hospital Stay > 48hrs for vaginal delivery or > 96 hours for c-section delivery
- Neonate: If neonate remains hospitalized beyond date of Mother's discharge or requires admission for non-routine nursery care
- Acute Inpatient Rehabilitation Admission (Ancillary charges do NOT require PA)
- Long Term Acute Care (LTAC)
- Skilled Nursing Facility
- All transplant services and transplant-related services
 - Cornea transplants do not require a prior authorization

ADDITION TO LOWER EXTREMITY			
CPT Code	Description	Effective Date	End Prior Approval Date
L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ ISCHIAL WEIGHT BEARING, RING	10-10-2019	
L2510	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI LATERAL BRIM, MOLDED TO PATIENT MODEL	10-10-2019	
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI LATERAL BRIM, CUSTOM FITTED	10-10-2019	
L2525	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M L BRIM MOLDED TO PATIENT MODEL	10-10-2019	
L2526	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M L BRIM, CUSTOM FITTED	10-10-2019	
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL	10-10-2019	
L2570	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE TWO POSITION JOINT, EACH	10-10-2019	
L2580	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PELVIC SLING	10-10-2019	
L2627	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PLASTIC, MOLDED TO PATIENT MODEL, RECIPROCATING HIP JOINT AND CABLES	10-10-2019	
L2628	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, METAL FRAME, RECIPROCATING HIP JOINT AND CABLES	10-10-2019	
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR	10-10-2019	



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

ADDITION TO LOWER EXTREMITY			
CPT Code	Description	Effective Date	End Prior Approval Date
L2755	ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, PER SEGMENT, FOR CUSTOM FABRICATED ORTHOSIS ONLY	10-10-2019	
L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)	10-10-2019	
L2768	ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER BAR	10-10-2019	
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NON CORROSIVE FINISH, PER BAR		
L2999	LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED	10-10-2019	
ADDITIONAL OXYGEN RELATED SUPPLIES AND EQUIPMENT			
CPT Code	Description	Effective Date	End Prior Approval Date
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	10-10-2019	
ADDITIONS TO LOWER EXTREMITY ORTHOSIS			
CPT Code	Description	Effective Date	End Prior Approval Date
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PATIENT MODEL, STIRRUP ATTACHMENT	10-10-2019	
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT	10-10-2019	
L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE	10-10-2019	
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL, FOR CUSTOM FABRICATED ORTHOSIS ONLY	10-10-2019	
L2340	ADDITION TO LOWER EXTREMITY, PRE TIBIAL SHELL, MOLDED TO PATIENT MODEL	10-10-2019	
L2350	ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)	10-10-2019	
Advance Care Planning			
CPT Code	Description	Effective Date	End Prior Approval Date
99498	ADVANCE CARE PLANNING INCLUDING THE EXPLANATION AND DISCUSSION OF ADVA	10-10-2019	



ANESTHESIA			
CPT Code	Description	Effective Date	End Prior Approval Date
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	10-10-2019	
AUDITORY SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
69710	IMPLANTATION OR REPLACEMENT OF ELECTROMAGNETIC BONE CONDUCTION HEARING	10-10-2019	
69711	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEVICE IN	10-10-2019	
69714	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOU	09-25-2023	
69715	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOU	09-25-2023	12-31-2021
69716	IMPLANTATION, OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR	09-25-2023	
69717	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IM	09-25-2023	
69718	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IM	09-25-2023	12-31-2021
69719	REVISION OR REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR	09-25-2023	
69726	REMOVAL, OSSEOINTEGRATED IMPLANT, SKULL; WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR	09-25-2023	
69727	REMOVAL, OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR	09-25-2023	
Automatic External Defibrillator			
CPT Code	Description	Effective Date	End Prior Approval Date
K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE	10-10-2019	



Behavioral Health Integration Care Management			
CPT Code	Description	Effective Date	End Prior Approval Date
99484	CARE MANAGEMENT SERVICES FOR BEHAVIORAL HEALTH CONDITIONS, AT LEAST 20 MINUTES OF CLINICAL STAFF TIME, DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH, WITH THE FOLLOWING REQUIRED ELEMENTS: INITIAL ASSESSMENT OR FOLLOW UP MONITORING, INCLUDING THE USE OF APPLICABLE VALIDATED RATING SCALES; BEHAVIORAL HEALTH CARE PLANNING IN RELATION TO BEHAVIORAL/PSYCHIATRIC HEALTH PROBLEMS, INCLUDING REVISION FOR PATIENTS WHO ARE NOT PROGRESSING OR WHOSE STATUS CHANGES; FACILITATING AND COORDINATING TREATMENT SUCH AS PSYCHOTHERAPY, PHARMACOTHERAPY, COUNSELING AND/OR PSYCHIATRIC CONSULTATION; AND CONTINUITY OF CARE WITH A DESIGNATED MEMBER OF THE CARE TEAM.	10-10-2019	
BREAST RECONSTRUCTION			
CPT Code	Description	Effective Date	End Prior Approval Date
19300	MASTECTOMY FOR GYNECOMASTIA	01-01-2026	
19303	Simple/total mastectomy	01-01-2026	
19305	Radical mastectomy	01-01-2026	
19306	Modified radical mastectomy	01-01-2026	
19307	Modified radical mastectomy with pectoralis minor removal	01-01-2026	
19316	MASTOPEXY	01-01-2026	
19318	Breast Reduction	10-10-2019	
19324	MAMMAPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT	01-01-2026	
19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT	01-01-2026	
19328	Removal of intact breast implant	01-01-2026	
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	01-01-2026	
19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTO	01-01-2026	
19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY	01-01-2026	
19350	NIPPLE/AREOLA RECONSTRUCTION	10-10-2019	



BREAST RECONSTRUCTION			
CPT Code	Description	Effective Date	End Prior Approval Date
19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INC	10-10-2019	
19361	BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITHOUT PROSTHETIC I	01-01-2026	
19364	BREAST RECONSTRUCTION WITH FREE FLAP	01-01-2026	
19367	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FL	01-01-2026	
19368	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FL	01-01-2026	
19369	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FL	01-01-2026	
19370	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST	01-01-2026	
19371	Periprosthetic capsulectomy, breast	01-01-2026	
19380	REVISION OF RECONSTRUCTED BREAST	01-01-2026	
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT	01-01-2026	
CARDIOVASCULAR SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
33940	DONOR CARDIECTOMY (INCLUDING COLD PRESERVATION)	10-10-2019	
36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN	10-10-2019	
36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG	09-09-2021	
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE	10-10-2019	
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE	10-10-2019	
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE	10-10-2019	
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE	10-10-2019	
37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTIO	10-10-2019	
37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN	10-10-2019	
37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM	10-10-2019	
37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOU	10-10-2019	
37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND	10-10-2019	



CARDIOVASCULAR SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS	10-10-2019	
37766	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; MORE THAN 20 INCISION	10-10-2019	
37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPLOPLITEAL JUNC	10-10-2019	
37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG	10-10-2019	
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	10-10-2019	
L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, RECHARGEABLE, INCLUDES EXTENSION	10-10-2019	
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON RECHARGEABLE, INCLUDES EXTENSION	10-10-2019	
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION	10-10-2019	
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON RECHARGEABLE, INCLUDES EXTENSION	10-10-2019	
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	10-10-2019	
CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)			
CPT Code	Description	Effective Date	End Prior Approval Date
96110	DEVELOPMENTAL SCREENING (EG, DEVELOPMENTAL MILESTONE SURVEY, SPEECH AN	10-10-2019	
96116	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONIN	10-10-2019	
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING (EG, ROSS INFORMATION PROCE	10-10-2019	
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT (EG, DEPRESSION INVENTORY, ATTEN	10-10-2019	
COMPLEX CHRONIC CARE COORDINATION SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
99489	COMPLEX CHRONIC CARE MANAGEMENT SERVICES, WITH THE FOLLOWING REQUIRED	10-10-2019	
99490	CHRONIC CARE MANAGEMENT SERVICES, AT LEAST 20 MINUTES OF CLINICAL STAF	10-10-2019	



DIAGNOSTIC/SCREENING PROCESSES OR RESULTS			
CPT Code	Description	Effective Date	End Prior Approval Date
37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLU	10-10-2019	
DIGESTIVE SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
42145	PALATOPHARYNGOPLASTY (EG, UVULOPALATOPHARYNGOPLASTY, UVULOPHARYNGOPLAS	10-10-2019	
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTI	10-10-2019	
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR	10-10-2019	
43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANT	10-10-2019	
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPE	10-10-2019	
44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR	10-10-2019	
44136	INTESTINAL ALLOTRANSPLANTATION; FROM LIVING DONOR	10-10-2019	
DOMICILIARY, REST HOME (ASSISTED LIVING FACILITY), OR HOME CARE PLAN OVERSIGHT SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
99341	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH R	10-10-2019	
Durable Medical Equipment			
CPT Code	Description	Effective Date	End Prior Approval Date
A4238	SUPPLY ALLOWANCE FOR ADJUNCTIVE, NON IMPLANTED CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES, 1 MONTH SUPPLY = 1 UNIT OF SERVICE	10-10-2019	
EMERGING TECHNOLOGY			
CPT Code	Description	Effective Date	End Prior Approval Date
0362T	EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER	10-10-2019	



EMERGING TECHNOLOGY

CPT Code	Description	Effective Date	End Prior Approval Date
0552T	LOW LEVEL LASER THERAPY, DYNAMIC PHOTONIC AND DYNAMIC THERMOKINETIC ENERGIES, PROVIDED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	10-10-2019	
0584T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; PERCUTANEOUS	10-10-2019	
0585T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; LAPAROSCOPIC	10-10-2019	
0586T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; OPEN	10-10-2019	

ENTERAL AND PARENTHAL PUMPS

CPT Code	Description	Effective Date	End Prior Approval Date
B9002	ENTERAL NUTRITION INFUSION PUMP, ANY TYPE	10-10-2019	
B9998	NOC FOR ENTERAL SUPPLIES	10-10-2019	

ENTERAL FORMULAE AND ENTERAL MEDICAL SUPPLIES

CPT Code	Description	Effective Date	End Prior Approval Date
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	10-10-2019	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	10-10-2019	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	10-10-2019	
B4081	NASOGASTRIC TUBING WITH STYLET	10-10-2019	
B4082	NASOGASTRIC TUBING WITHOUT STYLET	10-10-2019	



ENTERAL FORMULAE AND ENTERAL MEDICAL SUPPLIES

CPT Code	Description	Effective Date	End Prior Approval Date
B4083	STOMACH TUBE LEVINE TYPE	10-10-2019	
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH	10-10-2019	
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW PROFILE, ANY MATERIAL, ANY TYPE, EACH	10-10-2019	
B4100	FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE	10-10-2019	
B4102	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G., CLEAR LIQUIDS), 500 ML = 1 UNIT	10-10-2019	
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G., CLEAR LIQUIDS), 500 ML = 1 UNIT	10-10-2019	
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G., FIBER)	10-10-2019	
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	



ENTERAL FORMULAE AND ENTERAL MEDICAL SUPPLIES

CPT Code	Description	Effective Date	End Prior Approval Date
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	10-10-2019	
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	10-10-2019	
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	10-10-2019	
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	

ENTERAL FORMULAE AND ENTERAL MEDICAL SUPPLIES

CPT Code	Description	Effective Date	End Prior Approval Date
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	10-10-2019	
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	10-10-2019	

Evaluation and Management

CPT Code	Description	Effective Date	End Prior Approval Date
99483	ASSESSMENT OF AND CARE PLANNING FOR A PATIENT WITH COGNITIVE IMPAIRMENT, REQUIRING AN INDEPENDENT HISTORIAN, IN THE OFFICE OR OTHER OUTPATIENT, HOME OR DOMICILIARY OR REST HOME, WITH ALL OF THE FOLLOWING REQUIRED ELEMENTS: COGNITION FOCUSED EVALUATION INCLUDING A PERTINENT HISTORY AND EXAMINATION; MEDICAL DECISION MAKING OF MODERATE OR HIGH COMPLEXITY; FUNCTIONAL ASSESSMENT (EG, BASIC AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING), INCLUDING DECISION MAKING CAPACITY; USE OF STANDARDIZED INSTRUMENTS FOR STAGING OF DEMENTIA (EG, FUNCTIONAL ASSESSMENT STAGING TEST [FAST], CLINICAL DEMENTIA RATING [CDR]); MEDICATION RECONCILIATION AND REVIEW FOR HIGH RISK MEDICATIONS; EVALUATION FOR NEUROPSYCHIATRIC AND BEHAVIORAL SYMPTOMS, INCLUDING DEPRESSION, INCLUDING USE OF STANDARDIZED SCREENING INSTRUMENT(S); EVALUATION OF SAFETY (EG, HOME), INCLUDING MOTOR VEHICLE OPERATION; IDENTIFICATION OF CAREGIVER(S), CAREGIVER KNOWLEDGE, CAREGIVER NEEDS, SOCIAL SUPPORTS, AND THE WILLINGNESS OF CAREGIVER TO TAKE	10-10-2019	



Evaluation and Management

CPT Code	Description	Effective Date	End Prior Approval Date
99493	SUBSEQUENT PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT, FIRST 60 MINUTES IN A SUBSEQUENT MONTH OF BEHAVIORAL HEALTH CARE MANAGER ACTIVITIES, IN CONSULTATION WITH A PSYCHIATRIC CONSULTANT, AND DIRECTED BY THE TREATING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, WITH THE FOLLOWING REQUIRED ELEMENTS: TRACKING PATIENT FOLLOW UP AND PROGRESS USING THE REGISTRY, WITH APPROPRIATE DOCUMENTATION; PARTICIPATION IN WEEKLY CASELOAD CONSULTATION WITH THE PSYCHIATRIC CONSULTANT; ONGOING COLLABORATION WITH AND COORDINATION OF THE PATIENT'S MENTAL HEALTH CARE WITH THE TREATING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL AND ANY OTHER TREATING MENTAL HEALTH PROVIDERS; ADDITIONAL REVIEW OF PROGRESS AND RECOMMENDATIONS FOR CHANGES IN TREATMENT, AS INDICATED, INCLUDING MEDICATIONS, BASED ON RECOMMENDATIONS PROVIDED BY THE PSYCHIATRIC CONSULTANT; PROVISION OF BRIEF INTERVENTIONS USING EVIDENCE BASED TECHNIQUES SUCH AS BEHAVIORAL ACTIVATION, MOTIVATIONAL INTERVIEWING, AND OTHER FOCUSED TR	10-10-2019	
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE	10-10-2019	

EYE AND OCULAR ADNEXA

CPT Code	Description	Effective Date	End Prior Approval Date
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)	10-10-2019	
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OT	10-10-2019	
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS F	10-10-2019	
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, IN	10-10-2019	
67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EX	10-10-2019	
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING	10-10-2019	
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RE	10-10-2019	



EYE AND OCULAR ADNEXA

CPT Code	Description	Effective Date	End Prior Approval Date
67909	REDUCTION OF OVERCORRECTION OF PTOSIS	10-10-2019	

FOOT-INSERT AND ARCH SUPPORT

CPT Code	Description	Effective Date	End Prior Approval Date
L3100	HALLUS VALGUS NIGHT DYNAMIC SPLINT, PREFABRICATED, OFF THE SHELF	10-10-2019	

FRACTURE ORTHOSES AND ADDITIONS

CPT Code	Description	Effective Date	End Prior Approval Date
L2106	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED	10-10-2019	
L2108	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED	10-10-2019	
L2112	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2114	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2116	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2126	KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED	10-10-2019	
L2128	KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED	10-10-2019	
L2132	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2134	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2136	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM	10-10-2019	



FRACTURE ORTHOSES AND ADDITIONS			
CPT Code	Description	Effective Date	End Prior Approval Date
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT	10-10-2019	
HCPCS LEVEL II			
CPT Code	Description	Effective Date	End Prior Approval Date
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	10-10-2019	
HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION			
CPT Code	Description	Effective Date	End Prior Approval Date
96151	HEALTH AND BEHAVIOR ASSESSMENT (EG, HEALTH-FOCUSED CLINICAL INTERVIEW,	10-10-2019	
96152	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; INDIV	10-10-2019	
96153	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; GROUP	10-10-2019	
96154	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; FAMIL	10-10-2019	
96155	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; FAMIL	10-10-2019	
96160	PT-FOCUSED HLTH RISK ASSMT	10-10-2019	
Health Behavior Assessment and Intervention			
CPT Code	Description	Effective Date	End Prior Approval Date
97129	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCHEDULES, INITIATING, ORGANIZING, AND SEQUENCING TASKS), DIRECT (ONE ON ONE) PATIENT CONTACT; INITIAL 15 MINUTES	10-10-2019	



Health Behavior Assessment and Intervention			
CPT Code	Description	Effective Date	End Prior Approval Date
97130	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCHEDULES, INITIATING, ORGANIZING, AND SEQUENCING TASKS), DIRECT (ONE ON ONE) PATIENT CONTACT; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	10-10-2019	
HEMIC AND LYMPHATIC SYSTEMS			
CPT Code	Description	Effective Date	End Prior Approval Date
38204	MANAGEMENT OF RECIPIENT HEMATOPOIETIC PROGENITOR CELL DONOR SEARCH AND	10-10-2019	
38205	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTA	10-10-2019	
38208	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; THAWING OF P	10-10-2019	
38209	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; THAWING OF P	10-10-2019	
38210	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; SPECIFIC CEL	10-10-2019	
38211	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; TUMOR CELL D	10-10-2019	
38213	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; PLATELET DEP	10-10-2019	
38214	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; PLASMA (VOLU	10-10-2019	
38215	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; CELL CONCENT	10-10-2019	
38230	BONE MARROW HARVESTING FOR TRANSPLANTATION; ALLOGENEIC	10-10-2019	
38232	BONE MARROW HARVESTING FOR TRANSPLANTATION; AUTOLOGOUS	10-10-2019	
38240	HEMATOPOIETIC PROGENITOR CELL (HPC); ALLOGENEIC TRANSPLANTATION PER DO	10-10-2019	
38241	HEMATOPOIETIC PROGENITOR CELL (HPC); AUTOLOGOUS TRANSPLANTATION	10-10-2019	
38242	ALLOGENEIC LYMPHOCYTE INFUSIONS	10-10-2019	
38243	HEMATOPOIETIC PROGENITOR CELL (HPC); HPC BOOST	10-10-2019	



HOME HEALTH SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
99342	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH R	10-10-2019	
99343	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH R	10-10-2019	12-31-2022
99344	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH R	10-10-2019	
99345	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH R	10-10-2019	
99347	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT	10-10-2019	
99348	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT	10-10-2019	
99349	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT	10-10-2019	
99350	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT	10-10-2019	
99500	HOME VISIT FOR PRENATAL MONITORING AND ASSESSMENT TO INCLUDE FETAL HEA	10-10-2019	
99501	HOME VISIT FOR POSTNATAL ASSESSMENT AND FOLLOW-UP CARE	10-10-2019	
99502	HOME VISIT FOR NEWBORN CARE AND ASSESSMENT	10-10-2019	
99503	HOME VISIT FOR RESPIRATORY THERAPY CARE (EG, BRONCHODILATOR, OXYGEN TH	10-10-2019	
99504	HOME VISIT FOR MECHANICAL VENTILATION CARE	10-10-2019	
99505	HOME VISIT FOR STOMA CARE AND MAINTENANCE INCLUDING COLOSTOMY AND CYST	10-10-2019	
99506	HOME VISIT FOR INTRAMUSCULAR INJECTIONS	10-10-2019	
99510	HOME VISIT FOR INDIVIDUAL, FAMILY, OR MARRIAGE COUNSELING	10-10-2019	
99511	HOME VISIT FOR FECAL IMPACTION MANAGEMENT AND ENEMA ADMINISTRATION	10-10-2019	
99512	HOME VISIT FOR HEMODIALYSIS	10-10-2019	
99600	UNLISTED HOME VISIT SERVICE OR PROCEDURE	10-10-2019	
HOME VISIT IM INJECTION			
CPT Code	Description	Effective Date	End Prior Approval Date
99507	HOME VISIT FOR CARE AND MAINTENANCE OF CATHETER(S) (EG, URINARY, DRAIN	10-10-2019	



INFUSION THERAPY			
CPT Code	Description	Effective Date	End Prior Approval Date
90785	INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PR	10-10-2019	
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	10-10-2019	
INTEGUMENTARY SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENI	10-10-2019	
10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENI	10-10-2019	
10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE	01-01-2026	
10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATE	01-01-2026	
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION	01-01-2026	
10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST	10-10-2019	
11719	TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER	01-01-2026	
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CO	01-01-2026	
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CO	10-10-2019	
11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT PROSTHESIS	10-10-2019	
15240	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FO	10-10-2019	
15271	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND	10-10-2019	
15272	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND	10-10-2019	
15275	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, N	10-10-2019	
15771	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE	10-10-2019	
15777	IMPLANTATION OF BIOLOGIC IMPLANT (EG, ACELLULAR DERMAL MATRIX) FOR SOF	01-01-2026	
15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)	10-10-2019	
15787	ABRASION; EACH ADDITIONAL 4 LESIONS OR LESS (LIST SEPARATELY IN ADDITI	10-10-2019	
15820	BLEPHAROPLASTY, LOWER EYELID;	10-10-2019	



INTEGUMENTARY SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD	10-10-2019	
15822	BLEPHAROPLASTY, UPPER EYELID;	10-10-2019	
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID	10-10-2019	
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY);	10-10-2019	
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY),	01-01-2026	
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL	10-10-2019	
MEDICAL NUTRITION THERAPY			
CPT Code	Description	Effective Date	End Prior Approval Date
97803	MEDICAL NUTRITION THERAPY; RE-ASSESSMENT AND INTERVENTION, INDIVIDUAL,	10-10-2019	
97804	MEDICAL NUTRITION THERAPY; GROUP (2 OR MORE INDIVIDUAL(S)), EACH 30 MI	10-10-2019	
MEDICAL RADIATION PHYSICS, DOSIMETRY,			
CPT Code	Description	Effective Date	End Prior Approval Date
77301	INTENSITY MODULATED RADIOTHERAPY PLAN, INCLUDING DOSE-VOLUME HISTOGRAM	10-10-2019	
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATED RADIATIO	10-10-2019	
MISCELLANEOUS PATHOLOGY AND LABORATORY TESTS			
CPT Code	Description	Effective Date	End Prior Approval Date
P9615	CATHETERIZATION FOR COLLECTION OF SPECIMEN(S) (MULTIPLE PATIENTS)	10-10-2019	
MISCELLANEOUS PUMPS AND MONITORS			
CPT Code	Description	Effective Date	End Prior Approval Date
E2102	ADJUNCTIVE, NON IMPLANTED CONTINUOUS GLUCOSE MONITOR OR RECEIVER	10-10-2019	
MOLECULAR PATHOLOGY			
CPT Code	Description	Effective Date	End Prior Approval Date
81321	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMAR	10-10-2019	



MOLECULAR PATHOLOGY			
CPT Code	Description	Effective Date	End Prior Approval Date
81380	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ON	10-10-2019	
81382	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); O	10-10-2019	
81383	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); 1	10-10-2019	
81401	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 2 (EG, 2-10 SNPS, 1 METHYLATED VA	10-10-2019	
MUSCULOSKELETAL SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
20560	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 1 OR 2 MUSCLE(S)	10-10-2019	
20561	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 3 OR MORE MUSCLES	10-10-2019	
21085	IMPRESSION AND CUSTOM PREPARATION; ORAL SURGICAL SPLINT	10-10-2019	
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE	09-09-2021	
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT	10-10-2019	
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)	10-10-2019	
21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, C	10-10-2019	
26535	ARTHROPLASTY, INTERPHALANGEAL JOINT; EACH JOINT	10-10-2019	
26536	ARTHROPLASTY, INTERPHALANGEAL JOINT; WITH PROSTHETIC IMPLANT, EACH JOI	10-10-2019	
28110	OSTECTOMY, PARTIAL EXCISION, FIFTH METATARSAL HEAD (BUNIONETTE) (SEPAR	10-10-2019	
28240	TENOTOMY, LENGTHENING, OR RELEASE, ABDUCTOR HALLUCIS MUSCLE	10-10-2019	
28285	CORRECTION, HAMMERTOE (EG, INTERPHALANGEAL FUSION, PARTIAL OR TOTAL PH	10-10-2019	
97763	ORTHOTIC(S)/PROSTHETIC(S) MANAGEMENT AND/OR TRAINING, UPPER EXTREMITY(IES), LOWER EXTREMITY(IES), AND/OR TRUNK, SUBSEQUENT ORTHOTIC(S)/PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES	10-10-2019	

NERVOUS SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
62322	NJX INTERLAMINAR LMBR/SAC	10-10-2019	
62323	NJX INTERLAMINAR LMBR/SAC	10-10-2019	
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL	10-10-2019	
63655	LAMINECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, PLATE/PADD	10-10-2019	
64590	INSERTION OR REPLACEMENT OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULS	10-10-2019	
64595	REVISION OR REMOVAL OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GEN	10-10-2019	
64999	UNLISTED PROCEDURE, NERVOUS SYSTEM	10-10-2019	
NEUROLOGY AND NEUROMUSCULAR PROCEDURES			
CPT Code	Description	Effective Date	End Prior Approval Date
95831	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; EXTREMITY (EX	10-10-2019	
95832	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; HAND, WITH OR	10-10-2019	
95833	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; TOTAL EVALUAT	10-10-2019	
95834	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; TOTAL EVALUAT	10-10-2019	
95851	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); EACH EXT	10-10-2019	
95852	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); HAND, WI	10-10-2019	
95857	CHOLINESTERASE INHIBITOR CHALLENGE TEST FOR MYASTHENIA GRAVIS	10-10-2019	
95992	CANALITH REPOSITIONING PROCEDURE(S) (EG, EPLEY MANEUVER, SEMONT MANEUV	10-10-2019	
96001	COMPREHENSIVE COMPUTER-BASED MOTION ANALYSIS BY VIDEO-TAPING AND 3D KI	10-10-2019	
ORTHOPEDIC FOOTWEAR			
CPT Code	Description	Effective Date	End Prior Approval Date
L3203	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR	10-10-2019	
L3207	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR	10-10-2019	
L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH	10-10-2019	



ORTHOPEDIC FOOTWEAR

CPT Code	Description	Effective Date	End Prior Approval Date
L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH	10-10-2019	
L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	10-10-2019	
L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH	10-10-2019	
L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH	10-10-2019	
L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH	10-10-2019	
L3230	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH	10-10-2019	
L3250	ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH	10-10-2019	
L3251	FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH	10-10-2019	
L3252	FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH	10-10-2019	
L3253	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH	10-10-2019	
L3254	NON STANDARD SIZE OR WIDTH	10-10-2019	
L3255	NON STANDARD SIZE OR LENGTH	10-10-2019	
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE	10-10-2019	

ORTHOTIC DEVICES - LOWER LIMB

CPT Code	Description	Effective Date	End Prior Approval Date
L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), POSITIONAL ORTHOSIS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	10-10-2019	
L1833	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF THE SHELF	10-10-2019	
L1834	KNEE ORTHOSIS, WITHOUT KNEE JOINT, RIGID, CUSTOM FABRICATED	10-10-2019	



ORTHOTIC DEVICES - LOWER LIMB

CPT Code	Description	Effective Date	End Prior Approval Date
L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIFLEXION ASSIST CALF BAND, CUSTOM FABRICATED	10-10-2019	
L1932	AFO, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L1940	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM FABRICATED	10-10-2019	
L1945	ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION), CUSTOM FABRICATED	10-10-2019	
L1950	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC, CUSTOM FABRICATED	10-10-2019	
L1951	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L1960	ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM FABRICATED	10-10-2019	
L1970	ANKLE FOOT ORTHOSIS, PLASTIC WITH ANKLE JOINT, CUSTOM FABRICATED	10-10-2019	
L1971	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L1980	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED	10-10-2019	
L1990	ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED	10-10-2019	
L2000	KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED	10-10-2019	
L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED	10-10-2019	



ORTHOTIC DEVICES - LOWER LIMB			
CPT Code	Description	Effective Date	End Prior Approval Date
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	10-10-2019	
L2010	KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED	10-10-2019	
L2020	KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOUBLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED	10-10-2019	
L2030	KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED	10-10-2019	
L2034	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, MEDIAL LATERAL ROTATION CONTROL, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	10-10-2019	
L2035	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, STATIC (PEDIATRIC SIZE), WITHOUT FREE MOTION ANKLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L2036	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, DOUBLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	10-10-2019	
L2037	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	10-10-2019	
L2038	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, WITH OR WITHOUT FREE MOTION KNEE, MULTI AXIS ANKLE, CUSTOM FABRICATED	10-10-2019	
ORTHOTIC DEVICES - UPPER LIMB			
CPT Code	Description	Effective Date	End Prior Approval Date
L3671	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	

ORTHOTIC DEVICES - UPPER LIMB

CPT Code	Description	Effective Date	End Prior Approval Date
L3674	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L3678	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF THE SHELF	10-10-2019	
L3702	ELBOW ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	10-10-2019	
L3720	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ ARM CUFFS, FREE MOTION, CUSTOM FABRICATED	10-10-2019	
L3730	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ ARM CUFFS, EXTENSION/ FLEXION ASSIST, CUSTOM FABRICATED	10-10-2019	
L3740	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL, CUSTOM FABRICATED	10-10-2019	
L3760	ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	10-10-2019	
L3761	ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, OFF THE SHELF	10-10-2019	

OTHER SERVICES AND PROCEDURES

CPT Code	Description	Effective Date	End Prior Approval Date
99199	UNLISTED SPECIAL SERVICE, PROCEDURE OR REPORT	10-10-2019	

OUTPATIENT PPS CODES

CPT Code	Description	Effective Date	End Prior Approval Date
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	10-10-2019	
C2614	PROBE, PERCUTANEOUS LUMBAR DISCECTOMY	10-10-2019	



PELVIC NON-OBSTETRICAL			
CPT Code	Description	Effective Date	End Prior Approval Date
76857	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION;	10-10-2019	
PHYSICAL MEDICINE AND REHABILITATION			
CPT Code	Description	Effective Date	End Prior Approval Date
97002	PHYSICAL THERAPY RE-EVALUATION	10-10-2019	
97003	OCCUPATIONAL THERAPY EVALUATION	10-10-2019	
97004	OCCUPATIONAL THERAPY RE-EVALUATION	10-10-2019	
97010	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	10-10-2019	
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL	10-10-2019	
97014	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (	10-10-2019	
97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES	10-10-2019	
97018	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH	10-10-2019	
97022	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL	10-10-2019	
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE	10-10-2019	
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED	10-10-2019	
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET	10-10-2019	
97032	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (	10-10-2019	
97033	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 M	10-10-2019	
97034	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; CONTRAST BATHS, EACH 15	10-10-2019	
97035	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINU	10-10-2019	
97036	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HUBBARD TANK, EACH 15 MI	10-10-2019	
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)	10-10-2019	
97110	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC E	10-10-2019	
97112	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR	10-10-2019	



PHYSICAL MEDICINE AND REHABILITATION			
CPT Code	Description	Effective Date	End Prior Approval Date
97113	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERA	10-10-2019	
97116	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING	10-10-2019	
97124	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCL	10-10-2019	
97139	UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)	10-10-2019	
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/MANIPULATION, MANUAL LYMP	10-10-2019	
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)	10-10-2019	
97161	PT EVAL LOW COMPLEX 20 MIN	10-10-2019	
97162	PT EVAL MOD COMPLEX 30 MIN	10-10-2019	
97163	PT EVAL HIGH COMPLEX 45 MIN	10-10-2019	
97164	PT RE-EVAL EST PLAN CARE	10-10-2019	
97165	OT EVAL LOW COMPLEX 30 MIN	10-10-2019	
97166	OT EVAL MOD COMPLEX 45 MIN	10-10-2019	
97167	OT EVAL HIGH COMPLEX 60 MIN	10-10-2019	
97168	OT RE-EVAL EST PLAN CARE	10-10-2019	
97169	ATHLETIC TRN EVAL LOW CMPLX	10-10-2019	
97170	ATHLETIC TRN EVAL MOD CMPLX	10-10-2019	
97171	ATHLETIC TRN EVAL HIGH CMPLX	10-10-2019	
97172	ATHLETIC TRN RE-EVAL PLAN CR	10-10-2019	
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DY	10-10-2019	
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMO	10-10-2019	
97535	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (AD	10-10-2019	
97537	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, M	10-10-2019	
97542	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING), EACH 15 MIN	10-10-2019	
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	10-10-2019	
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN	10-10-2019	
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTI	10-10-2019	
97606	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTI	10-10-2019	

PHYSICAL MEDICINE AND REHABILITATION			
CPT Code	Description	Effective Date	End Prior Approval Date
97607	NEGATIVE PRESSURE WOUND THERAPY, (EG, VACUUM ASSISTED DRAINAGE COLLECT	10-10-2019	
97608	NEGATIVE PRESSURE WOUND THERAPY, (EG, VACUUM ASSISTED DRAINAGE COLLECT	10-10-2019	
97610	LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND, INCLUDING TOPICAL	10-10-2019	
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIO	10-10-2019	
97755	ASSISTIVE TECHNOLOGY ASSESSMENT (EG, TO RESTORE, AUGMENT OR COMPENSATE	10-10-2019	
97760	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING ASSESSMENT AND FITTING	10-10-2019	
97761	PROSTHETIC TRAINING, UPPER AND/OR LOWER EXTREMITY(S), EACH 15 MINUTES	10-10-2019	
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE	10-10-2019	
PNEUMATIC COMPRESSOR AND APPLIANCES(LYMPHEDEMA PUMP)			
CPT Code	Description	Effective Date	End Prior Approval Date
E0665	NON SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	10-10-2019	
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG		
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM	10-10-2019	
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG	10-10-2019	
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)	10-10-2019	
POWER OPERATED VEHICLE			
CPT Code	Description	Effective Date	End Prior Approval Date
E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER	10-10-2019	

Power Wheelchair			
CPT Code	Description	Effective Date	End Prior Approval Date
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	10-10-2019	
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	

Power Wheelchair			
CPT Code	Description	Effective Date	End Prior Approval Date
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10-10-2019	
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE	10-10-2019	
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10-10-2019	
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	

Power Wheelchair			
CPT Code	Description	Effective Date	End Prior Approval Date
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10-10-2019	
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10-10-2019	
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS	10-10-2019	
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	

Power Wheelchair			
CPT Code	Description	Effective Date	End Prior Approval Date
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10-10-2019	
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10-10-2019	
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	10-10-2019	
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	

Power Wheelchair			
CPT Code	Description	Effective Date	End Prior Approval Date
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10-10-2019	
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10-10-2019	
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	10-10-2019	
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	10-10-2019	
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	10-10-2019	
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA	10-10-2019	
POWER WHEELCHAIR ACCESSORIES			
CPT Code	Description	Effective Date	End Prior Approval Date
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	10-10-2019	
PRIVATE PAYER CODES			
CPT Code	Description	Effective Date	End Prior Approval Date
S1030	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, PURCHASE (FOR PHYSICIAN INTERPRETATION OF DATA, USE CPT CODE)	10-10-2019	
S1031	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, RENTAL, INCLUDING SENSOR, SENSOR REPLACEMENT, AND DOWNLOAD TO MONITOR (FOR PHYSICIAN INTERPRETATION OF DATA, USE CPT CODE)	10-10-2019	
S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION	10-10-2019	
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	10-10-2019	

PRIVATE PAYER CODES

CPT Code	Description	Effective Date	End Prior Approval Date
S2067	BREAST RECONSTRUCTION OF A SINGLE BREAST WITH "STACKED" DEEP 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 THE FLAP INTO A BREAST, UNILATERAL	10-10-2019	
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, UNILATERAL	10-10-2019	
S2140	CORD BLOOD HARVESTING FOR TRANSPLANTATION, ALLOGENEIC	10-10-2019	
S2142	CORD BLOOD DERIVED STEM CELL TRANSPLANTATION, ALLOGENEIC	10-10-2019	
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	10-10-2019	
S2348	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, USING RADIOFREQUENCY ENERGY, SINGLE OR MULTIPLE LEVELS, LUMBAR	01-01-2026	
S2350	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; LUMBAR, SINGLE INTERSPACE	01-01-2026	
S2351	DISKECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; LUMBAR, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	01-01-2026	
S3601	EMERGENCY STAT LABORATORY CHARGE FOR PATIENT WHO IS HOMEBOUND OR RESIDING IN A NURSING FACILITY	10-10-2019	



PRIVATE PAYER CODES

CPT Code	Description	Effective Date	End Prior Approval Date
S5180	HOME HEALTH RESPIRATORY THERAPY, INITIAL EVALUATION	10-10-2019	
S5181	HOME HEALTH RESPIRATORY THERAPY, NOS, PER DIEM	10-10-2019	
S5522	HOME INFUSION THERAPY, INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), NURSING SERVICES ONLY (NO SUPPLIES OR CATHETER INCLUDED)	10-10-2019	
S5523	HOME INFUSION THERAPY, INSERTION OF MIDLINE VENOUS CATHETER, NURSING SERVICES ONLY (NO SUPPLIES OR CATHETER INCLUDED)	10-10-2019	
S8948	APPLICATION OF A MODALITY (REQUIRING CONSTANT PROVIDER ATTENDANCE) TO ONE OR MORE AREAS; LOW LEVEL LASER; EACH 15 MINUTES	10-10-2019	
S8950	COMPLEX LYMPHEDEMA THERAPY, EACH 15 MINUTES	10-10-2019	
S9001	HOME UTERINE MONITOR WITH OR WITHOUT ASSOCIATED NURSING SERVICES	10-10-2019	
S9092	Canolith repositioning, per visit	10-10-2019	
S9097	HOME VISIT FOR WOUND CARE	10-10-2019	
S9098	HOME VISIT, PHOTOTHERAPY SERVICES (E.G., BILI LITE), INCLUDING EQUIPMENT RENTAL, NURSING SERVICES, BLOOD DRAW, SUPPLIES, AND OTHER SERVICES, PER DIEM	10-10-2019	
S9110	TELEMONITORING OF PATIENT IN THEIR HOME, INCLUDING ALL NECESSARY EQUIPMENT; COMPUTER SYSTEM, CONNECTIONS, AND SOFTWARE; MAINTENANCE; PATIENT EDUCATION AND SUPPORT; PER MONTH	10-10-2019	
S9122	HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT, PROVIDING CARE IN THE HOME; PER HOUR	10-10-2019	
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)	10-10-2019	
S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR	10-10-2019	
S9127	SOCIAL WORK VISIT, IN THE HOME, PER DIEM	10-10-2019	
S9128	SPEECH THERAPY, IN THE HOME, PER DIEM	10-10-2019	
S9129	OCCUPATIONAL THERAPY, IN THE HOME, PER DIEM	10-10-2019	
S9131	PHYSICAL THERAPY; IN THE HOME, PER DIEM	10-10-2019	
S9152	SPEECH THERAPY, RE EVALUATION	10-10-2019	



PRIVATE PAYER CODES

CPT Code	Description	Effective Date	End Prior Approval Date
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)	10-10-2019	
S9209	HOME MANAGEMENT OF PRETERM PREMATURE RUPTURE OF MEMBRANES (PPROM), 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)	10-10-2019	
S9211	HOME MANAGEMENT OF GESTATIONAL HYPERTENSION, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFUSION PER DIEM CODE)	10-10-2019	
S9212	HOME MANAGEMENT OF POSTPARTUM HYPERTENSION, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFUSION PER DIEM CODE)	10-10-2019	
S9213	HOME MANAGEMENT OF PREECLAMPSIA, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING SERVICES CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFUSION PER DIEM CODE)	10-10-2019	
S9214	HOME MANAGEMENT OF GESTATIONAL DIABETES, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFUSION PER DIEM CODE)	10-10-2019	



PRIVATE PAYER CODES

CPT Code	Description	Effective Date	End Prior Approval Date
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	
S9435	MEDICAL FOODS FOR INBORN ERRORS OF METABOLISM	10-10-2019	
S9460	DIABETIC MANAGEMENT PROGRAM, NURSE VISIT	10-10-2019	
S9465	DIABETIC MANAGEMENT PROGRAM, DIETITIAN VISIT	10-10-2019	
S9470	NUTRITIONAL COUNSELING, DIETITIAN VISIT	10-10-2019	
S9472	CARDIAC REHABILITATION PROGRAM, NON PHYSICIAN PROVIDER, PER DIEM	10-10-2019	
S9473	PULMONARY REHABILITATION PROGRAM, NON PHYSICIAN PROVIDER, PER DIEM	10-10-2019	
S9474	ENTEROSTOMAL THERAPY BY A REGISTERED NURSE CERTIFIED IN ENTEROSTOMAL THERAPY, PER DIEM	10-10-2019	
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	10-10-2019	
S9484	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER HOUR	10-10-2019	
S9485	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER DIEM	10-10-2019	



PROCEDURES/PROFESSIONAL SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
G0151	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
G0152	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
G0153	SERVICES PERFORMED BY A QUALIFIED SPEECH LANGUAGE PATHOLOGIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
G0155	SERVICES OF CLINICAL SOCIAL WORKER IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES	10-10-2019	
G0156	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES	10-10-2019	
G0157	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
G0158	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
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	10-10-2019	
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	10-10-2019	
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	10-10-2019	
G0162	SKILLED SERVICES BY A REGISTERED NURSE (RN) FOR MANAGEMENT AND EVALUATION OF THE PLAN OF CARE; EACH 15 MINUTES (THE PATIENT'S UNDERLYING CONDITION OR COMPLICATION REQUIRES AN RN TO ENSURE THAT ESSENTIAL NON SKILLED CARE ACHIEVES ITS PURPOSE IN THE HOME HEALTH OR HOSPICE SETTING)	10-10-2019	
G0168	WOUND CLOSURE UTILIZING TISSUE ADHESIVE(S) ONLY	10-10-2019	



PROCEDURES/PROFESSIONAL SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
G0175	SCHEDULED INTERDISCIPLINARY TEAM CONFERENCE (MINIMUM OF THREE EXCLUSIVE OF PATIENT CARE NURSING STAFF) WITH PATIENT PRESENT	10-10-2019	
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)	10-10-2019	
G0177	TRAINING AND EDUCATIONAL SERVICES RELATED TO THE CARE AND TREATMENT OF PATIENT'S DISABLING MENTAL HEALTH PROBLEMS PER SESSION (45 MINUTES OR MORE)	10-10-2019	
G0237	THERAPEUTIC PROCEDURES TO INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, FACE TO FACE, ONE ON ONE, EACH 15 MINUTES (INCLUDES MONITORING)	10-10-2019	
G0238	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION, OTHER THAN DESCRIBED BY G0237, ONE ON ONE, FACE TO FACE, PER 15 MINUTES (INCLUDES MONITORING)	10-10-2019	
G0239	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION OR INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, TWO OR MORE INDIVIDUALS (INCLUDES MONITORING)	10-10-2019	
G0270	MEDICAL NUTRITION THERAPY; REASSESSMENT AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), INDIVIDUAL, FACE TO FACE WITH THE PATIENT, EACH 15 MINUTES	10-10-2019	
G0271	MEDICAL NUTRITION THERAPY, REASSESSMENT AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION, OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), GROUP (2 OR MORE INDIVIDUALS), EACH 30 MINUTES	10-10-2019	

PROCEDURES/PROFESSIONAL SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
G0281	ELECTRICAL STIMULATION, (UNATTENDED), 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	10-10-2019	
G0282	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0281	10-10-2019	
G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE	10-10-2019	
G0295	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0329 OR FOR OTHER USES	10-10-2019	
G0299	DIRECT SKILLED NURSING SERVICES OF A REGISTERED NURSE (RN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
G0300	DIRECT SKILLED NURSING SERVICES OF A LICENSED PRACTICAL NURSE (LPN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	10-10-2019	
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	10-10-2019	
G0341	PERCUTANEOUS ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	10-10-2019	
G0342	LAPAROSCOPY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	10-10-2019	
G0343	LAPAROTOMY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	10-10-2019	
G0409	SOCIAL WORK AND PSYCHOLOGICAL SERVICES, DIRECTLY RELATING TO AND/OR FURTHERING THE PATIENT'S REHABILITATION GOALS, EACH 15 MINUTES, FACE TO FACE; INDIVIDUAL (SERVICES PROVIDED BY A CORF QUALIFIED SOCIAL WORKER OR PSYCHOLOGIST IN A CORF)	10-10-2019	

PROCEDURES/PROFESSIONAL SERVICES

CPT Code	Description	Effective Date	End Prior Approval Date
G0410	GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE FAMILY GROUP, IN A PARTIAL HOSPITALIZATION OR INTENSIVE OUTPATIENT SETTING, APPROXIMATELY 45 TO 50 MINUTES	10-10-2019	
G0411	INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION OR INTENSIVE OUTPATIENT SETTING, APPROXIMATELY 45 TO 50 MINUTES	10-10-2019	
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)	10-10-2019	
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)	10-10-2019	
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)	10-10-2019	
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	10-10-2019	
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	10-10-2019	
G0506	COMPREHENSIVE ASSESSMENT OF AND CARE PLANNING FOR PATIENTS REQUIRING CHRONIC CARE MANAGEMENT SERVICES (LIST SEPARATELY IN ADDITION TO PRIMARY MONTHLY CARE MANAGEMENT SERVICE)	10-10-2019	



PROCEDURES/PROFESSIONAL SERVICES

CPT Code	Description	Effective Date	End Prior Approval Date
G0659	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM), EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE), PERFORMED WITHOUT METHOD OR DRUG SPECIFIC CALIBRATION, WITHOUT MATRIX MATCHED QUALITY CONTROL MATERIAL, OR WITHOUT USE OF STABLE ISOTOPE OR OTHER UNIVERSALLY RECOGNIZED INTERNAL STANDARD(S) FOR EACH DRUG, DRUG METABOLITE OR DRUG CLASS PER SPECIMEN; QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, ANY NUMBER OF DRUG CLASSES	10-10-2019	
G6015	INTENSITY MODULATED TREATMENT DELIVERY, SINGLE OR MULTIPLE FIELDS/ARCS,VIA NARROW SPATIALLY AND TEMPORALLY MODULATED BEAMS, BINARY, DYNAMIC MLC, PER TREATMENT SESSION	10-10-2019	12-31-2025
G6016	COMPENSATOR BASED BEAM MODULATION TREATMENT DELIVERY OF INVERSE PLANNED TREATMENT USING 3 OR MORE HIGH RESOLUTION (MILLED OR CAST) COMPENSATOR, CONVERGENT BEAM MODULATED FIELDS, PER TREATMENT SESSION	10-10-2019	12-31-2025

Psychiatric Collaborative Care Management Services

CPT Code	Description	Effective Date	End Prior Approval Date
99492	INITIAL PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT, FIRST 70 MINUTES IN THE FIRST CALENDAR MONTH OF BEHAVIORAL HEALTH CARE MANAGER ACTIVITIES, IN CONSULTATION WITH A PSYCHIATRIC CONSULTANT, AND DIRECTED BY THE TREATING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, WITH THE FOLLOWING REQUIRED ELEMENTS: OUTREACH TO AND ENGAGEMENT IN TREATMENT OF A PATIENT DIRECTED BY THE TREATING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; INITIAL ASSESSMENT OF THE PATIENT, INCLUDING ADMINISTRATION OF VALIDATED RATING SCALES, WITH THE DEVELOPMENT OF AN INDIVIDUALIZED TREATMENT PLAN; REVIEW BY THE PSYCHIATRIC CONSULTANT WITH MODIFICATIONS OF THE PLAN IF RECOMMENDED; ENTERING PATIENT IN A REGISTRY AND TRACKING PATIENT FOLLOW UP AND PROGRESS USING THE REGISTRY, WITH APPROPRIATE DOCUMENTATION, AND PARTICIPATION IN WEEKLY CASELOAD CONSULTATION WITH THE PSYCHIATRIC CONSULTANT; AND PROVISION OF BRIEF INTERVENTIONS USING EVIDENCE BASED TECHNIQUES SUCH AS BEHAVIORAL ACTIVATION, MOTIVATIONAL INT	10-10-2019	
99494	INITIAL OR SUBSEQUENT PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT, EACH ADDITIONAL 30 MINUTES IN A CALENDAR MONTH OF BEHAVIORAL HEALTH CARE MANAGER ACTIVITIES, IN CONSULTATION WITH A PSYCHIATRIC CONSULTANT, AND DIRECTED BY THE TREATING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	10-10-2019	

PSYCHIATRY

CPT Code	Description	Effective Date	End Prior Approval Date
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	10-10-2019	
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	10-10-2019	
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFO	10-10-2019	
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	10-10-2019	



PSYCHIATRY			
CPT Code	Description	Effective Date	End Prior Approval Date
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFO	10-10-2019	
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	10-10-2019	
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFO	10-10-2019	
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	10-10-2019	
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY	10-10-2019	
90845	PSYCHOANALYSIS	10-10-2019	
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)	10-10-2019	
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)	10-10-2019	
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY	10-10-2019	
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	10-10-2019	
90863	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION AND REVIEW OF MEDICAT	10-10-2019	
90865	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES (EG	10-10-2019	
90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATME	10-10-2019	
90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATME	10-10-2019	
90869	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATME	10-10-2019	
90870	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING)	10-10-2019	
90875	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING BIOFEEDBACK TRAIN	10-10-2019	
90876	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING BIOFEEDBACK TRAIN	10-10-2019	
90882	ENVIRONMENTAL INTERVENTION FOR MEDICAL MANAGEMENT PURPOSES ON A PSYCHI	10-10-2019	
90887	INTERPRETATION OR EXPLANATION OF RESULTS OF PSYCHIATRIC, OTHER MEDICAL	10-10-2019	
90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE	10-10-2019	

PULMONARY			
CPT Code	Description	Effective Date	End Prior Approval Date
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT (PATIENT N	10-10-2019	
94664	DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL G	10-10-2019	
94667	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO	10-10-2019	
94668	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO	10-10-2019	
94669	MECHANICAL CHEST WALL OSCILLATION TO FACILITATE LUNG FUNCTION, PER SES	10-10-2019	
94780	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NUR	10-10-2019	
94781	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NUR	10-10-2019	
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE	10-10-2019	
RESPIRATORY SYSTEM			
CPT Code	Description	Effective Date	End Prior Approval Date
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF	10-10-2019	
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID,	10-10-2019	
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR	10-10-2019	
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK	10-10-2019	
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOM	10-10-2019	
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES	10-10-2019	
30468	REPAIR OF NASAL VALVE COLLAPSE WITH SUBCUTANEOUS/SUBMUCOSAL LATERAL WALL IMPLANT(S)	10-10-2019	
30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING,	10-10-2019	
30901	CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED CAUTERY AND/OR PAC	10-10-2019	
32851	LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS	10-10-2019	

RESTRAINTS			
CPT Code	Description	Effective Date	End Prior Approval Date
E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST OR ANKLE)	10-10-2019	
SAFETY EQUIPMENT			
CPT Code	Description	Effective Date	End Prior Approval Date
E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE	10-10-2019	
SPECIAL DERMATOLOGICAL PROCEDURES			
CPT Code	Description	Effective Date	End Prior Approval Date
97001	PHYSICAL THERAPY EVALUATION	10-10-2019	
SPECIAL OTORHINOLARYNGOLOGIC SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY P	10-10-2019	
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY P	10-10-2019	
92520	LARYNGEAL FUNCTION STUDIES (IE, AERODYNAMIC TESTING AND ACOUSTIC TEST)	10-10-2019	
92521	EVALUATION OF SPEECH FLUENCY (EG, STUTTERING, CLUTTERING)	10-10-2019	
92522	EVALUATION OF SPEECH SOUND PRODUCTION (EG, ARTICULATION, PHONOLOGICAL	10-10-2019	
92523	EVALUATION OF SPEECH SOUND PRODUCTION (EG, ARTICULATION, PHONOLOGICAL	10-10-2019	
92524	BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE	10-10-2019	
92526	Treatment of swallowing dysfunction and/or oral function for feeding	02-05-2020	
92605	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND	10-10-2019	
92606	THERAPEUTIC SERVICE(S) FOR THE USE OF NON-SPEECH-GENERATING DEVICE, IN	10-10-2019	
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALT	10-10-2019	
92610	EVALUATION OF ORAL AND PHARYNGEAL SWALLOWING FUNCTION	10-10-2019	
92611	MOTION FLUOROSCOPIC EVALUATION OF SWALLOWING FUNCTION BY CINE OR VIDEO	10-10-2019	



SPECIAL OTORHINOLARYNGOLOGIC SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
92618	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND	10-10-2019	
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	10-10-2019	
92627	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUT	02-05-2020	
92630	AUDITORY REHABILITATION; PRELINGUAL HEARING LOSS	10-10-2019	
92633	AUDITORY REHABILITATION; POSTLINGUAL HEARING LOSS	10-10-2019	
SPEECH-LANGUAGE PATHOLOGY SERVICES			
CPT Code	Description	Effective Date	End Prior Approval Date
V5362	SPEECH SCREENING	10-10-2019	
V5363	LANGUAGE SCREENING	10-10-2019	
V5364	DYSPHAGIA SCREENING	10-10-2019	
SPINAL - THORACIC - LUMBAR - SACRAL			
CPT Code	Description	Effective Date	End Prior Approval Date
L0484	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD CAM MODEL, CUSTOM FABRICATED	10-10-2019	
STATE MEDICAID AGENCY CODES			
CPT Code	Description	Effective Date	End Prior Approval Date
T2034	CRISIS INTERVENTION, WAIVER; PER DIEM	10-10-2019	
SUPRV INTERFACILTY TRANSPORT			
CPT Code	Description	Effective Date	End Prior Approval Date
99487	COMPLEX CHRONIC CARE MANAGEMENT SERVICES, WITH THE FOLLOWING REQUIRED	10-10-2019	



TEMPORARY CODES			
CPT Code	Description	Effective Date	End Prior Approval Date
Q2041	AXICABTAGENE CILOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI CD19 CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE	10-10-2019	
Q2042	TISAGENLECLEUCEL, UP TO 600 MILLION CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE	10-10-2019	
Q2052	SERVICES, SUPPLIES AND ACCESSORIES USED IN THE HOME FOR THE ADMINISTRATION OF INTRAVENOUS IMMUNE GLOBULIN (IVIG)	10-10-2019	
Q2053	BREXUCABTAGENE AUTOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI CD19 CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE	10-10-2019	
Q2054	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI CD19 CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE	10-10-2019	
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	10-10-2019	
THERAPEUTIC, PREVENTIVE OR OTHER INTERVENTIONS			
CPT Code	Description	Effective Date	End Prior Approval Date
41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY	10-10-2019	
Therapeutic continuous glucose monitors			
CPT Code	Description	Effective Date	End Prior Approval Date
K0553	SUPPLY ALLOWANCE FOR THERAPEUTIC CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES, 1 MONTH SUPPLY = 1 UNIT OF SERVICE	10-10-2019	12-31-2022
K0554	RECEIVER (MONITOR), DEDICATED, FOR USE WITH THERAPEUTIC GLUCOSE CONTINUOUS MONITOR SYSTEM	10-10-2019	



TORSION CONTROL			
CPT Code	Description	Effective Date	End Prior Approval Date
L2050	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	10-10-2019	
L2060	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	10-10-2019	
L2080	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	10-10-2019	
L2090	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	10-10-2019	
TRANSCUTANEOUS AND/OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATORS - TENS			
CPT Code	Description	Effective Date	End Prior Approval Date
E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION	10-10-2019	
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	10-10-2019	
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)	10-10-2019	
E0740	NON IMPLANTED PELVIC FLOOR ELECTRICAL STIMULATOR, COMPLETE SYSTEM	10-10-2019	
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	10-10-2019	
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	10-10-2019	
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE	10-10-2019	
Transitional Care Management Services			
CPT Code	Description	Effective Date	End Prior Approval Date
99495	TRANSITIONAL CARE MANAGEMENT SERVICES WITH THE FOLLOWING REQUIRED ELEM	10-10-2019	
99496	TRANSITIONAL CARE MANAGEMENT SERVICES WITH THE FOLLOWING REQUIRED ELEM	10-10-2019	
99497	ADVANCE CARE PLANNING INCLUDING THE EXPLANATION AND DISCUSSION OF ADVA	10-10-2019	

ULTRAVIOLET CABINET

CPT Code	Description	Effective Date	End Prior Approval Date
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	10-10-2019	
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION	10-10-2019	

URINARY SYSTEM

CPT Code	Description	Effective Date	End Prior Approval Date
50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NE	10-10-2019	
50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHR	10-10-2019	

WHEELCHAIRS

CPT Code	Description	Effective Date	End Prior Approval Date
K0010	STANDARD WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR	10-10-2019	
K0011	STANDARD WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING	10-10-2019	
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR	10-10-2019	
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE	10-10-2019	

WHEELCHAIRS;LIGHTWEIGHT AND HEAVY DUTY

CPT Code	Description	Effective Date	End Prior Approval Date
E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT IN SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	10-10-2019	
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT IN SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	10-10-2019	
E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT IN SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	10-10-2019	
E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT IN SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	10-10-2019	
E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	10-10-2019	
E1236	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	10-10-2019	
E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	10-10-2019	



WHEELCHAIRS;LIGHTWEIGHT AND HEAVY DUTY

CPT Code	Description	Effective Date	End Prior Approval Date
E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	10-10-2019	
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	10-10-2019	

WOUND DRESSINGS

CPT Code	Description	Effective Date	End Prior Approval Date
A6550	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	10-10-2019	