Non-Covered Services

Harvard Pilgrim Does Not Reimburse[1]

Harvard Pilgrim Health Care does not reimburse for the procedures or categories of codes outlined in this policy. This list is *not* all-inclusive.

Denials include non-covered services defined as exclusions in the members evidence of coverage (EOC), payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment. Member or provider liability is indicated. Benefits may vary; please call the Provider Service Center at 800-708-4414 for benefit determination including covered benefits selected by the member's employer group and the applicable benefit limitations and cost sharing. Any coverage exceptions are noted in the "Comments" column.

Harvard Pilgrim does not reimburse for the following code categories.

Category II CPT Codes (XXXXF)

Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes. These codes are intended to facilitate data collection about quality of care. Denies provider liable — procedure code not eligible for payment.

Category III CPT Codes (XXXXT)

Temporary codes for emerging technology, services and procedures. Services that deny with a Harvard Pilgrim explanation code of "65" should be resubmitted with an unlisted code. Supporting documentation is required with the claim.

Bundled Services/Supplies (Status "B" or "T" Procedure)

Codes identified with a CMS indicator of "B" or "T" (bundled code) will not be separately reimbursed to physicians by Harvard Pilgrim. Payments for these procedures are always bundled into payment for other services and separate payment is never made. Denies provider liable procedure code not eligible for payment.

"C" codes

These are temporary HCPCS codes established by CMS for use under the Hospital Outpatient Prospective Payment System (OPPS). Harvard Pilgrim will reimburse most "C" codes to outpatient facilities and ambulatory surgery centers only. See coding grid for exclusions.

"D" codes

Dental procedure codes. Denies member liable — not a covered service. Dental benefits may vary greatly among employer groups. For benefit determination, call the Provider Service Center at 800-708-4414. Please refer to the *Dental Payment Policy* for covered dental services.

Quality Measurement Codes

These codes are intended to facilitate data collection about quality of care. Denies provider liable — procedure code not eligible for payment.

PC/TC Indicator 5 Codes

Harvard Pilgrim denies "Incident To" codes identified with a CMS PC/TC indicator 5 when reported in a facility place of service when billed by a physician. Denies provider liable — procedure code not eligible for payment.

"S" codes

Private Payor codes. Temporary codes for private payer use. Harvard Pilgrim does not reimburse "S" codes except for a limited number of contracts. Denies provider liable — procedure code not eligible for payment. Services that deny with a Harvard Pilgrim explanation code of "65" should be resubmitted with an unlisted code. Supporting documentation is required with the claim.

"T" codes

HCPCS codes exclusively for the use of state Medicaid agencies. Harvard Pilgrim does not reimburse "T" codes except for a limited number of contracts. Denies provider liable — procedure code not eligible for payment.

Billing Unlisted Codes for Non-Covered Services

Services or procedures that do not have specific CPT or HCPCS codes are billed with unlisted codes. Supporting documentation is required with the claim. Refer to the "Non-covered services" section at the end of this table. This list is not all-inclusive.

Experimental or Investigational Procedures

Services or procedures that are experimental, unproven, or investigational and not supported by evidence-based medicine and established peer reviewed scientific data are not covered. This may include, but is not limited to, drugs, devices, treatments, procedures, and laboratory and pathology tests. Denies provider liable — procedure code not eligible for payment.

Code	Narrative	Denial reason code or description	Comments
0001M	Infectious disease, HCV, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	Provider liable — procedure code not eligible for payment	
0002M–0003M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and alcoholic/nonalcoholic steatohepatitis	Provider liable — procedure code not eligible for payment	
0098T	Revision of total disc arthroplasty, anterior approach; each additional interspace	Member liable — not a covered service	
0133T	Upper GI endoscopy, incl esoph, stomach and duod and/or jejun, w/injection implantable material, lower esophageal sphincter	Member liable — not a covered service	
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace	Member liable — not a covered service	
0164T	Removal of total disc arthroplasty, anterior approach, lumbar, each additional interspace	Member liable — not a covered service	
0165T	Revision of total disc arthroplasty, anterior approach, lumbar, each additional interspace	Member liable — not a covered service	
0182T	High dose rate electronic brachytherapy per fraction	Provider liable — procedure code not eligible for payment	
11951	Subcutan inj filling matl (e.g., collagen); 1.1 to 5.0 cc	Member liable — not a covered service	
11952	Subcutans inj filling matl (e.g., collagen); 5.1 to 10.0 cc	Member liable — not a covered service	
11954	Subcutan inj filling matl (e.g., collagen); over 10.0 cc	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
15775, 15776	Punch graft for hair transplant	Member liable — not a covered service	
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling	Member liable — not a covered service	
15781	Dermabrasion; segmental, face	Member liable — not a covered service	
15782	Dermabrasion; regional, other than face	Member liable — not a covered service	
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)	Member liable — not a covered service	
15786	Abrasion; single lesion (e.g., keratosis, scar)	Member liable — not a covered service	
15787	Abrasion, each additional four lesions or less	Member liable — not a covered service	
15788	Chemical peel, facial, epidermal	Member liable — not a covered service	
15789	Chemical peel/facial/dermal	Member liable — not a covered service	
15792	Chemical peel nonfacial/epidermal	Member liable — not a covered service	
15793	Chemical peel/nonfacial/dermal	Member liable — not a covered service	
15819	Cervicoplasty	Member liable — not a covered service	
15829	Rhytidectomy; subcutaneous musculoaponeurotic system (SMAS) flap	Member liable — not a covered service	
15837	Excision, excessive skin and subcut tissue; forearm, hand	Member liable — not a covered service	
15838	Excision, excess skin and subcut tissue; submental fat pad	Member liable — not a covered service	
15850	Removal of sutures under anesthesia (other than local), same surgeon	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
17360	Chemical exfoliation for acne (e.g., acne paste, acid)	Member liable — not a covered service	
17380	Electrolysis epilation, each 1/2 hour	Member liable — not a covered service	
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Provider liable — procedure code not eligible for payment	
19396	Preparation of moulage for custom breast implant	Member liable — not a covered service	
20930	Allograft for spine surgery only; morselized	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
20936	Allograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision	Provider liable — payment included in the allowance of another service	
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (list separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)	Provider liable — procedure code not eligible for payment	
21280	Medial canthopexy	Member liable — not a covered service	
21282	Lateral canthopexy	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
21295, 21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy)	Member liable — not a covered service	
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Provider liable — procedure code not eligible for payment.	
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (list separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment.	
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	Provider liable — procedure code not eligible for payment.	
22841	Internal spinal fixation by wiring of spinous processes	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace	Provider liable — procedure code not eligible for payment	
22862	Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace	Provider liable — procedure code not eligible for payment	
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace	Provider liable — procedure code not eligible for payment	
28890	Extracorporeal shockwave, hi energy, by MD, incl u/s guidance, involv plantar fascia	Provider liable — procedure code not eligible for payment	
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Provider liable — procedure code not eligible for payment	
30210	Displacement therapy (Proetz type)	Provider liable — procedure code not eligible for payment	
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data	Provider liable — procedure code not eligible for payment	
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)	Provider liable — payment included in the allowance of another service	
36430	Transfusion, blood or blood components	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
36468	Injections of sclerosing solutions, spider veins; limb or TR	Member liable — not a covered service	
37195	Thrombolysis, cerebral, by intravenous infusion	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
37788	Penile revascularization, artery, w/without vein graft	Member liable — not a covered service	
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	Provider liable — payment included in the allowance of another service	
38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
41512	Tongue base suspension, permanent suture technique	Provider liable — procedure code not eligible for payment	
41530	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session	Provider liable — procedure code not eligible for payment	
41821	Operculectomy, excision pericoronal tissues	Member liable — not a covered service	
41828	Excision of hyperplastc alveolr mucosa, each sextant or quad	Member liable — not a covered service	
41830	Alveolectomy, including curettage of osteitis or sequestrect	Member liable — not a covered service	
41870	Periodontal mucosal grafting	Member liable — not a covered service	
43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance	Provider liable — procedure code not eligible for payment	
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Provider liable — procedure code not eligible for payment	
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance	Provider liable — procedure code not eligible for payment	
43257	Upper GI endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia for TX of GI reflux disease	Provider liable — procedure code not eligible for payment	
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed	Provider liable — procedure code not eligible for payment	
43285	Removal of esophageal sphincter augmentation device	Provider liable — procedure code not eligible for payment	
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Provider liable — procedure code not eligible for payment	
43754	Gastric intubation and aspiration, diagnostic; single specimen (e.g., acid analysis)	Provider liable — procedure code not eligible for payment	
43755	Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (e.g., histamine, insulin, pentagastrin, calcium, secretin), includes drug administration	Provider liable — procedure code not eligible for payment	
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Provider liable — procedure code not eligible for payment	
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Provider liable — procedure code not eligible for payment	
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Provider liable — procedure code not eligible for payment	
51020	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
51030	Cystotomy or cystostomy; with cryosurgical destruction of intravesical lesion	Provider liable — procedure code not eligible for payment	
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography	Provider liable — procedure code not eligible for payment	
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	Provider liable — procedure code not eligible for payment	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Provider liable — procedure code not eligible for payment	
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Provider liable — procedure code not eligible for payment	
55400	Vasovasostomy, vasovasorrhaphy	Member liable — not a covered service	
55705	Biopsy, prostate; incisional, any approach	Provider liable — procedure code not eligible for payment	
55720	Prostatotomy, external drainage of prostatic abscess, any approach; simple	Provider liable — procedure code not eligible for payment	
55725	Prostatotomy, external drainage of prostatic abscess, any approach; complicated	Provider liable — procedure code not eligible for payment	
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Provider liable — procedure code not eligible for payment	
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy)	Provider liable — procedure code not eligible for payment	
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Provider liable — procedure code not eligible for payment	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Provider liable — procedure code not eligible for payment	
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Provider liable — procedure code not eligible for payment	
64585	Revision or removal of peripheral neurostimulator electrode array	Provider liable — procedure code not eligible for payment	
65760	Keratomileusis	Member liable — not a covered service	
65765	Keratophakia	Member liable — not a covered service	
65767	Epikeratoplasty	Member liable — not a covered service	
65771	Radial keratotomy	Member liable — not a covered service	
65782	Ocular surface reconstruction, limbal conjunctival autograft	Member liable — not a covered service	
69090	Ear piercing	Member liable — not a covered service	
69209	Remove impacted cerumen, unilateral	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to

Code	Narrative	Denial reason code or description	Comments
			coverage details on page 1.
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Provider liable — procedure code not eligible for payment	
76390	Magnetic resonance spectroscopy	Provider liable — procedure code not eligible for payment	
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Provider liable — payment included in the allowance of another service	Reimbursed as of dates of service on or after April 1, 2021.
77071	Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated	Provider liable — payment included in the allowance of another service	
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
80320–80377, 83992	Definitive Drug Testing	Provider liable — procedure code not eligible for payment	
81500, 81503	Oncology (ovarian), biochemical assays	Provider liable — procedure code not eligible for payment	
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes	Provider liable — procedure code not eligible for payment	
81508–81512	Fetal congenital abnormalities, biochemical assays	Provider liable — procedure code not eligible for payment	
82024	Adrenocorticotropic hormone (ACTH)	Provider liable — procedure code not eligible for payment	
82495	Chromium	Provider liable — procedure code not eligible for payment	
82930	Gastric acid analysis, includes pH if performed, each specimen	Provider liable — procedure code not eligible for payment	
82965	Glutamate dehydrogenase	Provider liable — procedure code not eligible for payment	
83993	Calprotectin, fecal	Provider liable — procedure code not eligible for payment	
84112	Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	Provider liable — procedure code not eligible for payment	
85345	Coagulation time; Lee and White	Provider liable — procedure code not eligible for payment	
85347	Coagulation time; activated	Provider liable — procedure code not eligible for payment	
85348	Coagulation time; other methods	Provider liable — procedure code not eligible for payment	
86185	Counterimmunoelectrophoresis, each antigen	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
86677	Antibody; Helicobacter pylori	Provider liable — procedure code not eligible for payment	
86910	Blood typing for paternity testing, per individual; ABO, RH and MN	Member liable — not a covered service	
86911	Blood typing for paternity test/per individ/abo/rh & mn/each add'l antigen	Member liable — not a covered service	
87622	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification	Provider liable — procedure code not eligible for payment	
88000–88016	Necropsy (autopsy), gross examination only, without CNS	Member liable — not a covered service	
88020–88029	Necropsy (autopsy), gross and microscopic, w/o CNS	Member liable — not a covered service	
88036–88037	Necropsy (autopsy), limited, gross and/or microscopic	Member liable — not a covered service	
88040–88045	Necropsy (autopsy), forensic examination; coroner's call	Member liable — not a covered service	
88099	Unlisted necropsy (autopsy) procedure	Member liable — not a covered service	
90471, 90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid); each additional vaccine	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	Provider liable — procedure code not eligible for payment	
90666–90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use; (preservative free; adjuvanted)	Provider liable — procedure code not eligible for payment	
90865	Narcosynthesis for psychiatric dx/therapeutic purposes	Member liable — not a covered service	
90880	Hypnotherapy	Member liable — not a covered service	
90882	Psych envir interven mental health off/opd	Provider liable — procedure code not eligible for payment	
90885	Psychiatric evaluation of hosp records, other psychiatric reports, other accum data for med diag purposes	Provider liable — payment included in the allowance of another service	
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
91052	Gastric analysis test with injection of stimulant of gastric secretion	Provider liable — procedure code not eligible for payment	
91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with physician interpretation and report	Provider liable — procedure code not eligible for payment	
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule with interpretation and report	Provider liable — procedure code not eligible for payment	
91132-91133	Electrogastrography, diagnostic, transcutaneous; without or with provocative testing	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
92311–92312	Prescription of opt & phys char of & fitting of contact lens	Member liable — not a covered service	
92316	Prescription of opt & phys char & fitting of contact lens, with medical supervision and direction of fitting, corneal lens for aphakia, both eyes	Member liable — not a covered service	
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	Member liable — not a covered service	
92326	Replacement of contact lens	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
92340	Fitting of spectacles, except for aphakia; nonfocal	Member liable — not a covered service	
92341	Fitting of spectacles, except for aphakia, bifocal	Member liable — not a covered service	
92342	Fitting of spectacles, except for aphakia, multifocal	Member liable — not a covered service	
92352	Fitting of spectacle prosthesis for aphakia, monofocal	Member liable — not a covered service	
92353	Fitting of spectacle prosthesis for aphakia; multifocal	Member liable — not a covered service	
92354	Fitting of spectacle mounted low vision aid; single element	Member liable — not a covered service	
92355	Fitting of spectacle mounted low vision aid; telescopic	Member liable — not a covered service	
92358	Prosthesis service for aphakia, temporary	Member liable — not a covered service	
92370	Repair and refitting spectacles, except for aphakia	Member liable — not a covered service	
92371	Repair and refitting spectacles, spectacle prosthesis for aphakia	Member liable — not a covered service	
92531	Spontaneous nystagmus, including gaze	Provider liable — payment included in the allowance of another service	
92532	Positional nystagmus test	Provider liable — payment included in the allowance of another service	
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)	Provider liable — payment included in the allowance of another service	
92534	Optokinetic nystagmus test	Provider liable — payment included in the allowance of another service	
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
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.)	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
92977	Thrombolysis, coronary; by intravenous infusion	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1

Code	Narrative	Denial reason code or description	Comments
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	Provider liable — procedure code not eligible for payment	
93740	Temperature gradient studies	Provider liable — procedure code not eligible for payment	
93770	Determination of venous pressure	Provider liable — payment included in the allowance of another service	
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Provider liable — procedure code not eligible for payment	
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan	Provider liable — payment included in the allowance of another service	
94150	Vital capacity, total (separate procedure)	Provider liable — payment included in the allowance of another service	
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
94642	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis	Provider liable — procedure code not eligible for payment	
94644, 94645	Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour; each additional hour	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
94667, 94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation; subsequent	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
94669	Mechanical chest wall oscillation to facilitate lung function, per session	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
94760, 94761	Noninvasive ear or pulse oximetry for oxygen saturation; single or multiple determination(s)	Provider liable — payment included in the allowance of another service	
94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	Provider liable — payment included in the allowance of another service	
95012	Nitric oxide expired gas determination	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1

Code	Narrative	Denial reason code or description	Comments
95044	Patch or application test(s) (specify number of tests)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
95052	Photo patch test(s) (specify number of tests)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
95056	Photo tests	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
95115, 95117	Professional services for allergen immunotherapy not including provision of allergenic extracts	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Provider liable — procedure code not eligible for payment	
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
95992	Canalith repositioning procedure(s) (e.g., epley maneuver semont maneuver) per day	Provider liable — payment included in the allowance of another service	
96160-96161	Administration of health risk assessment instrument	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96360, 96361	Intravenous infusion, hydration	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96365, 96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug);	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to

Code	Narrative	Denial reason code or description	Comments
			coverage details on page 1
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96409, 96411	Chemotherapy administration; intravenous, push technique	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96413, 96415	Chemotherapy administration, intravenous infusion technique	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96420	Chemotherapy administration, intra-arterial; push technique	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96422, 96423	Chemotherapy administration, intra-arterial; infusion technique	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to

Code	Narrative	Denial reason code or description	Comments
			coverage details on page 1
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96521	Refilling and maintenance of portable pump	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96523	Irrigation of implanted venous access device for drug delivery systems	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g., lip) by activation of photosensitive drug(s), each phototherapy exposure session	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96900	Actinotherapy (ultraviolet light)	Provider liable — procedure code not eligible for payment	
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	Provider liable — payment included in the allowance of another service	
96904	Whole body integumentary photography, for monitoring of high-risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	Provider liable — procedure code not eligible for payment	
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	Provider liable — procedure code not eligible for payment	
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)	Provider liable — procedure code not eligible for payment	
97010	Application of a modality to 1 or more areas; hot or cold packs	Provider liable — payment included in the allowance of another service	
97022	Modality one or more areas, whirlpool	Provider liable — payment included in the allowance of another service	
97150	Group therapeutic procedure(s)	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
97169-97172	Athletic training evaluation or re-evaluation	Member liable — not a covered service	
97545	Work hardening/conditioning, initial two hours	Provider liable — procedure code not eligible for payment	
97546	Work hardening/conditioning, each additional hour	Provider liable — procedure code not eligible for payment	
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressing, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	Provider liable — payment included in the allowance of another service	
97750	Physical perform test or measurement, w/written report, each 15 min.	Member liable — not a covered service	
97810	Acupuncture, one or more needles, without electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient	Member liable — not a covered service	
97811	Acupuncture, one or more needles, without electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	Member liable — not a covered service	
97813	Acupuncture, one or more needles, with electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient	Member liable — not a covered service	
97814	Acupuncture, one or more needles, with electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)	Member liable — not a covered service	
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
98961	Education/training for patient self-management by qual, non-MD health care professional w/standard curriculum, face/face w/patient (caregiver, family) each 30 mins.; 2–4 patients	Member liable — not a covered service	
98962	Education/training for patient self-management by qual, non-MD health care professional w/standard curriculum, face/face w/patient (caregiver, family) each 30 mins.; 5–8 patients	Member liable — not a covered service	
98966–98968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days	Provider liable — procedure code not eligible for payment	
99000, 99001	Handling and/or conveyance of specimen for transfer	Provider liable — payment included in the allowance of another service	
99002	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices	Provider liable — payment included in the allowance of another service	
99024	Postoperative follow-up visit, included in global service	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
99026	Hospital mandated on call srvc, in-hospital, each hour	Provider liable — procedure code not eligible for payment	
99027	Hospital mandated on call srvc, out-of-hospital, each hour	Provider liable — procedure code not eligible for payment	
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	Provider liable — payment included in the allowance of another service	
99053	Services provided 10 p.m.–8 a.m. at a 24-hour facility, in addition to basic service	Provider liable — payment included in the allowance of another service	
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	Provider liable — payment included in the allowance of another service	
99058	Office services provided on an emergency basis	Provider liable — payment included in the allowance of another service	
99060	Services provided on an emergency basis out of the office which disrupts other scheduled office services in addition to basic service	Provider liable — payment included in the allowance of another service	
99070	Materials charges	Provider liable — payment included in the allowance of another service	
99071	Educational supplies	Member liable — not a covered service	
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other nonfacility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease	Provider liable-Not separately reimbursed	
99075	Medical testimony	Member liable — not a covered service	
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	Provider liable — payment included in the allowance of another service	
99080	Special reports	Provider liable — procedure code not eligible for payment	
99082	Unusual travel (e.g., transportation and escort of patient)	Member liable — not a covered service	
99091	Collection and interpretation of physiologic data (e.g., ecg, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes	Provider liable — payment included in the allowance of another service	
99100	Anesthesia for patient of extreme age, under one year & over 70	Provider liable — payment included in the allowance of another service	
99116	Anesthesia complicated by utilization of total body hypothermia	Provider liable — payment included in the allowance of another service	
99135	Anesthesia complicated by utilization of controlled hypotension	Provider liable — payment included in the allowance of another service	
99140	Anesthesia complicated by emergency conditions (specify)	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
99195	Phlebotomy, therapeutic (separate procedure)	Provider liable — procedure code not eligible for payment	
99199	Unlisted special service, procedure or report	Provider liable — payment included in the allowance of another service	
99241-99245	Office consultation for a new or established patient	Provider liable — procedure code not eligible for payment	No longer reimbursed as of dates of service on or after November 1, 2021
99251-99255	Inpatient consultation for a new or established patient	Provider liable — procedure code not eligible for payment	No longer reimbursed as of dates of service on or after November 1, 2021
99288	Physician direction of emergency medical systems (ems) emergency care, advanced life support	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
99354	Prolonged phys svc in office or opd, face-to-face, first hour	Provider liable — payment included in the allowance of another service	
99355	Prolong phys serv in office/op/each additional 30 minutes	Provider liable — payment included in the allowance of another service	
99356	Prolonged phys serv/in pat/requiring direct (face-to-face) patient contact	Provider liable — payment included in the allowance of another service	
99357	Prolonged phys serv/in pat/requiring direct patient contact, each add'l 30 minutes	Provider liable — payment included in the allowance of another service	
99358	Prolonged eval & mgt serv/non-direct care/in pat/first hour	Provider liable — payment included in the allowance of another service	
99359	Prolonged eval & mgt serv/non-direct/in pat/add'l 30 minutes	Provider liable — payment included in the allowance of another service	
99360	Phys standby serv/prolonged attend/each 30 minutes	Provider liable — payment included in the allowance of another service	
99366–99368	Medical team conference with interdisciplinary team of health care professionals	Provider liable — procedure code not eligible for payment	
99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient evaluation and management service)	Provider liable — procedure code not eligible for payment	
99416	Prolonged clinical staff service, each additional 30 minutes	Provider liable — procedure code not eligible for payment	
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Provider liable — payment included in the allowance of another service	
99442, 99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian	Provider liable — procedure code not eligible for payment	
99446-99449	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; medical consultative discussion and review	Provider liable — payment included in the allowance of another service	Reimbursed for facility only
99450	Life/disability evaluation	Member liable — not a covered service	
99455, 99456	Disability examination	Member liable — not a covered service	
99473, 99474	Self-Measured blood pressure using a device	Provider liable — procedure code not eligible for payment	
99487–99489	Complex chronic care coordination services	Provider liable — payment included in the allowance of another service	
99490	Chronic care management services	Provider liable — payment included in the allowance of another service	
99605–99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided	Provider liable — procedure code not eligible for payment	
A0021	Ambulance service outside state	Member liable — not a covered service	
A0080	Non-emergency transportation: per mile–volunteer with no personal interest	Member liable — not a covered service	
A0090	Non-emergency transportation: per mile– vehicle provided by individual w/vested interest	Member liable — not a covered service	
A0100, A0110, A0120, A0140, A0170, A0180, A0190, A0200, A0210	Non-emergency transportation	Member liable — not a covered service	
A0420	Ambulance service waiting time (one half-hour)	Provider liable — payment included in the allowance of another service	
A0424	Ambulance service extra attendant	Member liable — not a covered service	
A0888	Ambulance service non-covered mileage	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
A4220	Refill kit implantable fusion pump	Provider liable — payment included in the allowance of another service	
A4233–A4236	Replacement batteries for use with medically necessary home blood glucose monitor owned by patient	Member liable — not a covered service	
A4262	Temp absorb lacrimal duct implant	Provider liable — payment included in the allowance of another service	
A4263	Perm non-dis lacrimal duct implant	Provider liable — payment included in the allowance of another service	
A4267	Contraceptive supply, condom, male, each	Member liable — not a covered service	
A4268	Contraceptive supply, condom, female, each	Member liable — not a covered service	
A4269	Contraceptive supply, spermacide (foam, gel), each	Member liable — not a covered service	
A4270	Disposable endoscope sheath, each	Provider liable — payment included in the allowance of another service	
A4300	Implantable access catheter (venous, arterial, epidural or peritoneal), extn	Provider liable — payment included in the allowance of another service	
A4305, A4306	Disposable drug delivery system/catheter	Provider liable — payment included in the allowance of another service	
A4450	Tape, non-waterproof, per 18 sq. in.	Member liable — not a covered service	
A4452	Tape, waterproof, per 18 sq. in.	Member liable — not a covered service	
A4455	Adhesive remover or solvent per ounce	Member liable — not a covered service	
A4458	Enema bag with tubing	Member liable — not a covered service	
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	Member liable — not a covered service	
A4461	Surgical dressing holder, non-reusable, each	Provider liable — payment included in the allowance of another service	
A4470	Gravlee jet washer	Member liable — not a covered service	
A4480	Vabra aspirator	Member liable — not a covered service	
A4520	Incontinence garment any type, each	Member liable — not a covered service	
A4534	Youth-sized incontinence product, brief, each	Member liable — not a covered service	
A4550	Surgical trays	Provider liable — payment included in the allowance of another service	
A4554	Disposable underpads all sizes	Member liable — not a covered service	
A4559	Coupling gel or paste, for use with ultrasound device, per oz	Provider liable — payment included in the allowance of another service	
A4575	Topical hyperbaric oxygen chamber, disposable	Member liable — not a covered service	
A4580	Cast supplies	Provider liable — procedure code not eligible for payment	
A4590	Special casting materials	Provider liable — procedure code not eligible for payment	
A4601	Lithium ion battery for non-prosthetic use, replacement	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each	Member liable — not a covered service	
A4638	Replacement battery for patient-owned ear pulse generator, each	Member liable — not a covered service	
A4639	Replacement pad for infrared heating pad system, each	Member liable — not a covered service	
A4641	Radiopharm diagnostic imaging agent noc	Provider liable — payment included in the allowance of another service	Coverage subject to manual review
A4649	Surgical supply; miscellaneous	Provider liable — payment included in the allowance of another service	Covered in the home location only
A4870	Plumbing and/or electrical work for home hemodialysis equipment	Member liable — not a covered service	
A4890	Contracts, repair and maintenance, for hemodialysis equipment	Member liable — not a covered service	
A4931	Oral thermometer, reusable, any type, each	Member liable — not a covered service	
A4932	Rectal thermometer, reusable, any type, each	Member liable — not a covered service	
A6025	Silicone gel sheet, each	Member liable — not a covered service	
A8000	Helmet, protective, soft, prefabricated, includes all components and accessories	Member liable — not a covered service	
A8001	Helmet, protective, hard, prefabricated, includes all components and accessories	Member liable — not a covered service	
A9150	Non-prescription drugs	Member liable — not a covered service	
A9270	Non-covered item or service	Member liable — not a covered service	
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	Provider liable — procedure code not eligible for payment	
A9280	Alert or alarm device, not otherwise classified	Member liable — not a covered service	
A9281	Reaching/grabbing device, any type, any length, each	Member liable — not a covered service	
A9300	Exercise equipment	Member liable — not a covered service	
A9510	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc99m	Provider liable — payment included in the allowance of another service	
A9700	Supply of injectable contrast material for use in echocardiography	Provider liable — payment included in the allowance of another service	
A9901	Delivery, set up, and/or dispensing service component of another HCPCS code	Provider liable — payment included in the allowance of another service	
B4216	Parent nutr additives	Provider liable — payment included in the allowance of another service	
B4220	Parent nutr supply kit premix	Provider liable — payment included in the allowance of another service	
B4222	Parent nutr supply kit home mix	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
B4224	Parent nutr administration kit	Provider liable — payment included in the allowance of another service	
B9004	Parent nutr infus pump portable	Provider liable — payment included in the allowance of another service	
B9006	Parent nutr infus pump stationary	Provider liable — payment included in the allowance of another service	
B9999	NOC parent supplies	Provider liable — payment included in the allowance of another service	
C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	Provider liable — procedure code not eligible for payment	
C1821	Interspinous process distraction device (implantable)	Provider liable — procedure code not eligible for payment	
C1841, C1842	Retinal prosthesis, includes all internal and external components	Provider liable — procedure code not eligible for payment	
C2614	Probe, percutaneous lumbar discectomy	Provider liable — procedure code not eligible for payment	
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	Provider liable — procedure code not eligible for payment	
E0118	Crutch substitute, lower leg platform, with or without wheels, ea.	Member liable — not a covered service	
E0160	Sitz bath port w/or w/out commode over seat	Member liable — not a covered service	
E0161	Sitz bath port w/or w/out commode w/faucet attach	Member liable — not a covered service	
E0162	Sitz bath chair	Member liable — not a covered service	
E0175	Footrest use w/commode chair	Member liable — not a covered service	
E0188	Synthetic sheepskin pad	Member liable — not a covered service	
E0189	Lambswool sheepskin pad any size	Member liable — not a covered service	
E0191	Heel/elbow protector ea.	Member liable — not a covered service	
E0199	Dry pressure pad for mattress, standard mattress length and width	Member liable — not a covered service	
E0200	Heat lamp w/o stand	Member liable — not a covered service	
E0205	Heat lamp w/stand	Member liable — not a covered service	
E0210	Electric heat pad std	Member liable — not a covered service	
E0215	Electric heat pad moist	Member liable — not a covered service	
E0217	Water circulating heat pad with pump	Member liable — not a covered service	
E0221	Infrared heating pad system	Member liable — not a covered service	
E0225	Hydrocollator unit includes pads	Member liable — not a covered service	
E0230	Ice cap/collar	Member liable — not a covered service	
E0239	Hydrocollator unit portable	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
E0240	Bath/shower chair, with or without wheels, any size	Member liable — not a covered service	
E0241	Bathtub wall rail ea	Member liable — not a covered service	
E0242	Bathtub rail floor base	Member liable — not a covered service	
E0243	Toilet rail ea	Member liable — not a covered service	
E0245	Tub stool/bench	Member liable — not a covered service	
E0246	Transfer tub rail attachment	Member liable — not a covered service	
E0247	Transfer bench for tub or toilet with or without commode opening	Member liable — not a covered service	
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode	Member liable — not a covered service	
E0272	Mattress foam rubber	Member liable — not a covered service	
E0274	Over-bed table	Member liable — not a covered service	
E0315	Bed accessory, board, table or support device, any type	Member liable — not a covered service	
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor	Provider liable — procedure code not eligible for payment	
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Member liable — not a covered service	
E0481	Intrapulmonary percussive ventilation system and related accessories	Member liable — not a covered service	
E0500	IPPPB machine w/built-in nebulizer	Member liable — not a covered service	
E0605	Vaporizer room type	Member liable — not a covered service	
E0610	Pacemaker monitor self-contained	Provider liable — payment included in the allowance of another service	
E0615	Pacemaker monitor self-contained	Provider liable — payment included in the allowance of another service	
E0616	Implantable cardiac event recorder w/memory, activator & programmer	Provider liable — payment included in the allowance of another service	
E0617	External defibrillator with integrated electrocardiogram analysis	Member liable — not a covered service	
E0625	Patient lift kartop bathroom	Member liable — not a covered service	
E0627	Seat lift mech in comb lift-chair	Member liable — not a covered service	
E0629	Sep seat lift mech reimbursed	Member liable — not a covered service	
E0639, E0640	Patient lift; includes all components/accessories	Member liable — not a covered service	
E0700	Safety equipment	Member liable — not a covered service	
E0740	Non-implanted pelvic floor electrical stimulator, complete system	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
E0765	FDA-approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting	Member liable — not a covered service	
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	Provider liable — procedure code not eligible for payment	
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or 'muscle groups, any type, complete system, not otherwise specified	Provider liable — procedure code not eligible for payment	
E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hrs or greater	Provider liable — payment included in the allowance of another service	
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours	Provider liable — payment included in the allowance of another service	
E0782	Infusion pump implantable non-programmable	Provider liable — payment included in the allowance of another service	
E0783	Infusion pump system, implantable, programmable	Provider liable — payment included in the allowance of another service	
E0786	Implantable programmable infusion pump, replacement	Provider liable — payment included in the allowance of another service	
E0791	Parent infus pump stationary	Provider liable — payment included in the allowance of another service	
E0890	Traction frame footboard pelvic	Provider liable — procedure code not eligible for payment	
E0900	Traction stand free pelvic trac	Provider liable — procedure code not eligible for payment	
E1037	Transport chair, pediatric size	Member liable — not a covered service	
E1038	Transport chair, adult size	Member liable — not a covered service	
E1300	Whirlpool portable (overtub)	Member liable — not a covered service	
E1310	Whirlpool non-port (built-in)	Member liable — not a covered service	
E1632	Wearable artificial kidney, each	Member liable — not a covered service	
E1635	Compact (portable) travel hemodialyzer system	Member liable — not a covered service	
E2610	Wheelchair seat cushion, powered	Member liable — not a covered service	
G0076-G0087	Care management home visit	Provider liable — procedure code not eligible for payment	
G0175	Scheduled interdisciplinary team conference (minimum of three exclusive)	Provider liable — payment included in the allowance of another service	
G0219	PET imaging whole body; melanoma for noncovered indications	Member liable — not a covered service	
G0235	PET imaging, any site, not otherwise specified	Provider liable — procedure code not eligible for payment.	
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1

Code	Narrative	Denial reason code or description	Comments
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, 2 or more individuals (includes monitoring)	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
G0252	PET imaging initial dx	Member liable — not a covered service	
G0269	Placement of occlusive device into either a venous or arterial access site, post-surgical or interventional procedure (e.g., angioseal plug, vascular plug)	Provider liable — payment included in the allowance of another service	
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)	Provider liable — payment included in the allowance of another service	Reimbursed as of dates of service on or after April 1, 2021.
G0293	Non-covered surgical procedure(s) using conscious sedation, regional, general, or spinal anesthesia in a Medicare-qualifying clinical trial, per day	Provider liable — procedure code not eligible for payment	
G0294	Non-covered surgical procedure(s) using either no anesthesia or local anesthesia only in a Medicare-qualifying clinical trial, per day	Provider liable — procedure code not eligible for payment	
G0295	Electromagnetic stimulation, to one or more areas	Provider liable — procedure code not eligible for payment	
G0302	Pre-operative pulmonary surgery services for preparation for LVRS, complete course of services	Provider liable — procedure code not eligible for payment	
G0303	Pre-operative pulmonary surgery services for preparation for LVRS, 10–15 days of services	Provider liable — procedure code not eligible for payment	
G0304	Pre-operative pulmonary surgery services for preparation for LVRS, one to nine days of service	Provider liable — procedure code not eligible for payment	
G0305	Post-discharge pulmonary surgery services after LVRS, minimum of six days	Provider liable — procedure code not eligible for payment	
G0306	Complete cbc, automated (HGB, HCT, RBC, WBC, without platelet count) and automated WBC diff count	Provider liable — procedure code not eligible for payment	
G0307	Complete (CBC), automated (HGB, HCT, RBC, WBC, without platelet count)	Provider liable — procedure code not eligible for payment	
G0329	Electromagnetic therapy, to one or more areas for chronic stage III or IV	Member liable — not a covered service	
G0333	Pharmacy dispensing fee for inhalation drug(s); initial 30-day supply as a beneficiary	Provider liable — payment included in the allowance of another service	
G0372	Physician service required to establish and document the need for a power mobility device	Provider liable — procedure code not eligible for payment	
G0378	Hospital observation service, per hour	Provider liable — procedure code not eligible for payment	
G0379	Direct admission of patient for hospital observation care	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
G0380–G0384	Levels 1–5; hospital emergency visit provided in a type b department or facility of the hospital	Provider liable — procedure code not eligible for payment	
G0390	Trauma response team associated with hospital critical care service	Provider liable — procedure code not eligible for payment	
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15–30 minutes	Provider liable — procedure code not eligible for payment	
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	Provider liable — procedure code not eligible for payment	
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Provider liable — procedure code not eligible for payment	
G0403-G0405	Electrocardiogram, routine ECG with 12 leads	Provider liable — procedure code not eligible for payment	
G0451	Development testing	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
G0454	Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist	Provider liable — procedure code not eligible for payment	
G0460	Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	Provider liable — procedure code not eligible for payment	
G0463	Hospital outpatient clinic visit for assessment and management of a patient	Provider liable — procedure code not eligible for payment	
G0464	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)	Provider liable — procedure code not eligible for payment	
G0466 - G0470	FQHC visit	Provider liable — procedure code not eligible for payment	
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion	Provider liable — procedure code not eligible for payment	PC/TC indicator 5 code. Refer to coverage details on page 1
G0513, G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service;	Provider liable — payment included in the allowance of another service	
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Provider liable — payment included in the allowance of another service	
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total 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 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)	Provider liable — payment included in the allowance of another service	
G9140	Frontier extended stay clinic demonstration; for a patient stay in a clinic approved for the CMS demonstration project	Provider liable — procedure code not eligible for payment	
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	Provider liable — procedure code not eligible for payment	
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	Provider liable — procedure code not eligible for payment	
G9148	National committee for quality assurance — level 1 medical home	Provider liable — procedure code not eligible for payment	
G9149	National committee for quality assurance — level 2 medical home	Provider liable — procedure code not eligible for payment	
G9150	National committee for quality assurance — level 3 medical home	Provider liable — procedure code not eligible for payment	
G9151	Mapcp demonstration - state provided services	Provider liable — procedure code not eligible for payment	
G9152	Mapcp demonstration - community health teams	Provider liable — procedure code not eligible for payment	
G9153	Mapcp demonstration - physician incentive pool	Provider liable — procedure code not eligible for payment	
G9156	Evaluation for wheelchair requiring face-to-face visit with physician	Provider liable — procedure code not eligible for payment	
H2016	Comprehensive community support services, per diem	Provider liable — procedure code not eligible for payment	
K0455	Infusion pump used for uninterrupted administration of epoprostenol	Provider liable — procedure code not eligible for payment	
K0601	Replacement battery for external infusion pump owned by patient, silver	Member liable — not a covered service	
K0602	Replacement battery for external infusion pump owned by patient, silver	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
K0603	Replacement battery for external infusion pump owned by patient, alkaline	Member liable — not a covered service	
K0604	Replacement battery for external infusion pump owned by patient, lith.	Member liable — not a covered service	
K0605	Replacement battery for external infusion pump owned by patient, lith.	Member liable — not a covered service	
K0669	Wheelchair seat or back cushion, no written coding verification	Member liable — not a covered service	
K0740	Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	Provider liable — payment included in the allowance of another service	
K0899	Power mobility device, not coded by SADMERC or does not meet criteria	Member liable — not a covered service	
K1003	Whirlpool tub	Member liable — not a covered service	
K1005	Disposable collection and storage bag for breast milk	Member liable — not a covered service	
L0220	Thoracic rib belt custom made	Member liable — not a covered service	
L1812	Knee orthosis, elastic with joints, prefabricated, off-the-shelf	Member liable — not a covered service	
L3170	Foot plastic heel stabilizer	Member liable — not a covered service	
L3201	Ortho shoe Oxford infant	Member liable — not a covered service	
L3202	Ortho shoe Oxford child	Member liable — not a covered service	
L3203	Ortho shoe Oxford junior	Member liable — not a covered service	
L3204	Ortho shoe hightop infant	Member liable — not a covered service	
L3206	Ortho shoe hightop child	Member liable — not a covered service	
L3207	Ortho shoe hightop junior	Member liable — not a covered service	
L3215	Ortho shoes ladies Oxford	Member liable — not a covered service	
L3216	Ortho shoes ladies depth inlay	Member liable — not a covered service	
L3217	Ortho shoes ladies hightop	Member liable — not a covered service	
L3219	Ortho shoes mens Oxford	Member liable — not a covered service	
L3221	Ortho shoes mens depth inlay	Member liable — not a covered service	
L3222	Ortho shoes mens hightop	Member liable — not a covered service	
L3224	Ortho shoes ladies Oxford used as part of brace	Member liable — not a covered service	
L3225	Ortho shoes mens Oxford used as part of brace	Member liable — not a covered service	
L3230	Ortho shoes custom depth inlay	Member liable — not a covered service	
L3250	Ortho shoes custom molded	Member liable — not a covered service	
L3251	Foot shoe molded to patient	Member liable — not a covered service	
L3252	Foot shoe molded to patient	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
L3253	Foot molded shoe plastazote	Member liable — not a covered service	
L3254	Non-std size/width	Member liable — not a covered service	
L3255	Non-std size/length	Member liable — not a covered service	
L3257	Ortho shoes add chrg split size	Member liable — not a covered service	
L3300	Lift elevation heel	Member liable — not a covered service	
L3310	Lift elevation heel & sole	Member liable — not a covered service	
L3320	Lift elevation heel & sole	Member liable — not a covered service	
L3330	Lift elevation metal extension	Member liable — not a covered service	
L3332	Lift elevation inside shoe	Member liable — not a covered service	
L3334	Lift elevation heel per inch	Member liable — not a covered service	
L3340	Heel wedge sach	Member liable — not a covered service	
L3350	Heel wedge	Member liable — not a covered service	
L3360	Sole wedge outside sole	Member liable — not a covered service	
L3370	Sole wedge between sole	Member liable — not a covered service	
L3380	Clubfoot wedge	Member liable — not a covered service	
L3390	Outflare wedge	Member liable — not a covered service	
L3400	Metatarsal bar wedge rocker	Member liable — not a covered service	
L3410	Metatarsal bar wedge betwn sole	Member liable — not a covered service	
L3420	Full sole & heel wedge betwn sole	Member liable — not a covered service	
L3430	Heel counter plastic reinforced	Member liable — not a covered service	
L3440	Heel counter leather reinforced	Member liable — not a covered service	
L3450	Heel sach cushion type	Member liable — not a covered service	
L3455	Heel new leather std	Member liable — not a covered service	
L3460	Heel new rubber std	Member liable — not a covered service	
L3465	Heel thomas w/wedge	Member liable — not a covered service	
L3470	Heel thomas extended to ball	Member liable — not a covered service	
L3480	Heel pad & depression spur	Member liable — not a covered service	
L3485	Heel pad removable spur	Member liable — not a covered service	
L3500	Orthopedic shoe addition, insole, leather	Member liable — not a covered service	
L3510	Orthopedic shoe addition, insole, rubber	Member liable — not a covered service	
L3520	Orthopedic shoe addition, insole, felt covered w/leather	Member liable — not a covered service	
L3530	Orthopedic shoe addition, sole, half	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
L3540	Orthopedic shoe addition, sole, full	Member liable — not a covered service	
L3550	Orthopedic shoe addition, toe tap, standard	Member liable — not a covered service	
L3560	Orthopedic shoe addition, toe tap, horseshoe	Member liable — not a covered service	
L3570	Orthopedic shoe addition, special extension to instep (leather w/eyelets)	Member liable — not a covered service	
L3580	Orthopedic shoe addition, convert instep to Velcro closure	Member liable — not a covered service	
L3590	Orthopedic shoe addition, convert firm shoe counter to soft counter	Member liable — not a covered service	
L3595	Orthopedic shoe addition, march bar	Member liable — not a covered service	
L6704	Terminal device, sport/recreational/work attachment, any material, any size	Member liable — not a covered service	
L8300	Truss single w/std pad	Member liable — not a covered service	
L8310	Truss dbl w/std pads	Member liable — not a covered service	
L8320	Truss add to std pad water pad	Member liable — not a covered service	
L8330	Truss add to std pad scrotal pad	Member liable — not a covered service	
L8605	Injectable bulking agent	Provider liable — procedure code not eligible for payment	
L8608	Miscellaneous external component, supply or accessory for use with the Argus II Retinal Prosthesis System	Provider liable — procedure code not eligible for payment	
L8609	Artificial cornea	Provider liable — payment included in the allowance of another service	
L8610	Ocular implant	Provider liable — payment included in the allowance of another service	
L8612	Aqueous shunt	Provider liable — payment included in the allowance of another service	
L8613	Ossicula implant	Provider liable — payment included in the allowance of another service	
L8622	Alkaline battery for use with cochlear implant device	Provider liable — payment included in the allowance of another service	
L8630	Metacarpophalangeal joint implant	Provider liable — payment included in the allowance of another service	
L8658	Interphalangeal joint implant	Provider liable — payment included in the allowance of another service	
L8670	Vascular graft material, synthetic, implant	Provider liable — payment included in the allowance of another service	
L8680	Implantable neurostimulator electrode, each	Provider liable — payment included in the allowance of another service	
L8701, L8702	Powered upper extremity range of motion assist device	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
M0075	Cellular therapy	Provider liable — procedure code not eligible for payment	
M0076	Prolotherapy	Provider liable — procedure code not eligible for payment	
M0100	Intragastric hypothermia using gastric freezing	Provider liable — procedure code not eligible for payment	
M0300	IV chelation therapy (chemical endarterectomy)	Provider liable — procedure code not eligible for payment	
M0301	Fabric wrapping of abdominal aneurysm	Provider liable — procedure code not eligible for payment	
P2028	Cephalin floculation, blood	Provider liable — procedure code not eligible for payment	
P2029	Congo red, blood	Provider liable — procedure code not eligible for payment	
P2033	Thymol turbidity, blood	Provider liable — procedure code not eligible for payment	
P2038	Mucoprotein, blood (seromucoid) (medical necessity procedure)	Provider liable — procedure code not eligible for payment	
Q0510–Q0512	Pharmacy supply fees	Provider liable — payment included in the allowance of another service	
Q0513–Q0514	Pharmacy dispensing fees	Provider liable — payment included in the allowance of another service	
Q2026	Injection, Radiesse, 0.1ml	Member liable — not a covered service	
Q2028	Injection, Sculptra, 0.5mg	Member liable — not a covered service	
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration	Provider liable — procedure code not eligible for payment	
Q3031	Collagen skin test	Provider liable — payment included in the allowance of another service	
Q4082	Drug or biological, not otherwise classified, part b drug competitive acquisition program (cap)	Provider liable — procedure code not eligible for payment	
Q5001–Q5010	Hospice care provided in various locations	Provider liable — procedure code not eligible for payment	
Q9958	High osmolar contrast material, up to 149 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
Q9959	High osmolar contrast material, 150–199 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
Q9960	High osmolar contrast material, 200–249 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
Q9961	High osmolar contrast material, 250–299 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
Q9962	High osmolar contrast material, 300–349 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	

Code	Narrative	Denial reason code or description	Comments
Q9963	High osmolar contrast material, 350–399 mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
Q9964	High osmolar contrast material, 400 or greater mg./ml. iodine concentration, per ml.	Provider liable — payment included in the allowance of another service	
R0075	Transportation of portable x-ray	Provider liable — payment included in the allowance of another service	
R0076	Transportation of portable EKG	Provider liable — payment included in the allowance of another service	
S1001	Deluxe item	Member liable — not a covered service	
S1030	Continuous noninvasive glucose monitoring device, purchase	Provider liable — procedure code not eligible for payment	
S1031	Continuous noninvasive glucose monitoring device, renta	Provider liable — procedure code not eligible for payment	
T4545	Incontinence product, disposable	Member liable — not a covered service	
V2600	Hand held low vision aids	Member liable — not a covered service	
V2610	Single lens spectacle mounted	Member liable — not a covered service	
V2615	Telescopic and other compound lens	Member liable — not a covered service	
V2630	Anterior chamber intraocular lens	Provider liable — payment included in the allowance of another service	
V2631	Iris supported intraocular lens	Provider liable — payment included in the allowance of another service	
V2632	Posterior chamber intraocular lens	Provider liable — payment included in the allowance of another service	
V2700	Balance lens, per lens	Member liable — not a covered service	
V2702	Deluxe lens feature	Member liable — not a covered service	
V2710	Slab off prism glass or plastic per lens	Member liable — not a covered service	
V2715	Prism per lens	Member liable — not a covered service	
V2718	Press-on lens, fresnell prism, per lens	Member liable — not a covered service	
V2730	Special base curve glass or plastic per lens	Member liable — not a covered service	
V2750	Anti-reflective coating per lens	Member liable — not a covered service	
V2756	Eyeglass case	Member liable — not a covered service	
V2760	Scratch-resistant coating	Member liable — not a covered service	
V2761	Mirror coating, any type, solid, gradient or equal, any lens material	Member liable — not a covered service	
V2762	Polarization, any lens material, per lens	Member liable — not a covered service	
V2770	Occluder lens per lens	Member liable — not a covered service	

Code	Narrative	Denial reason code or description	Comments
V2780	Oversize lens per lens	Member liable — not a covered service	
V2781	Progressive lens, per lens	Member liable — not a covered service	
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	Member liable — not a covered service	
V2783	Lens, index grtr than or equal to 1.66 plastic or grtr than or equal to 1.80 glass, excludes polycarbonate, per lens	Member liable — not a covered service	
V2784	Lens, polycarbonate or equal, any index, per lens	Member liable — not a covered service	
V2786	Specialty occupational multifocal lens, per lens	Member liable — not a covered service	
V2787	Astigmatism-correcting function of intraocular lens	Member liable — not a covered service	
V2788	Presbyopia correcting function of intraocular lens	Member liable — not a covered service	
V2790	Amniotic membrane for surgical reconstruction, per procedure	Provider liable — payment included in the allowance of another service	
V2797	Vision supply, accessory and/or service component of another HCPCS vision code	Member liable — not a covered service	
V2799	Vision service miscellaneous	Member liable — not a covered service	
V5266	Battery for use in hearing device	Member liable — not a covered service	
V5275	Ear impression, each	Member liable — not a covered service	
V5281–V5290	Assistive listening device	Member liable — not a covered service	
210X (2100–2109)	Alternative therapy services	Member liable — not a covered service	All services billed under these revenue codes
310X (3100–3109)	Adult care	Member liable — not a covered service	
0663, 0669	Daily respite care; Other respite care	Member liable — not a covered service	
0951	Athletic training	Member liable — not a covered service	
099X (0990–0999)	Patient convenience items	Member liable — not a covered service	
093X (0930–0932)	Medical rehabilitation day program	Provider liable — procedure code not eligible for payment	
081X (0810–0819)	Acquisition of body components	Provider liable — procedure code not eligible for payment	
068X (0680–0689)	Trauma response	Provider liable — procedure code not eligible for payment	

Code	Narrative	Denial reason code or description	Comments
Non-covered services billed under unlisted codes:, laser assisted uvuloplasty, Lasik laser, excimer laser, EXMI, mandibular/TMJ appliances, Diri dynamic infrared imaging, pillar palatal implants, pulsed radiofrequency ablation, gastroendoplication, scintimmamography, SNAP testing, esophogeal PillCam, pergonal monitoring, I-Port catheters, mobile cardiac outpatient telemetry (MCOT), Neutralizing antibody testing (NAB) in multiple sclerosis, ROSE procedure, virtual colonoscopy, recombinant human bone morphogene Protein 7 (RBMP7), SMARTPILL, somnoplasty, infrasonic sound treatment, laproscopic mini gastric bypass surgery (MGB), platelet-rich plasma injections, in vitro chemosensitivity, chemoresistance assays, bronchial thermoplasty, mild procedure and shoulder resurfacing.		Provider liable — procedure code not eligible for payment	

PUBLICATION HISTORY

10/31/05	original documentation
01/31/06	quarterly coding update
04/30/06	quarterly coding update
10/31/06	quarterly coding update
01/31/07	quarterly coding update
04/31/07	quarterly coding update
10/31/07	quarterly coding update
01/31/08	quarterly coding update
07/31/08	quarterly coding update
10/31/08	quarterly coding update
01/15/09	quarterly coding update
03/15/09	coding update
06/15/09	update codes, added experimental and investigational category for clarification
10/15/09	quarterly coding update
12/15/09	coding update
01/15/10	annual coding update
04/15/10	quarterly coding update
07/15/10	quarterly coding update
09/15/10	added edits for clarification
10/15/10	coding update
11/15/10	added PC/TC indicator 5 category denial
01/15/11	annual coding update
02/15/11	coding update
04/15/11	added Category III coding; added EX65 rebilling info to S codes
05/15/11	coding update
06/15/11	coding update
10/15/11	coding update
01/15/12	annual coding update
03/15/12	edits made for clarity
06/15/12	quarterly coding update; added M codes; removed sleeve gastrectomy from unlisted codes
07/15/12	added coverage criteria for 92313, V2531 and E0602
10/15/12	coding update; added A9279
01/15/13	annual coding update
03/15/13	updated rebilling of “C” codes, added covered effective 01/01/13 for 81200-81383 and 81400-81408
04/15/13	added Bundled Services/Supplies category, removed “reimbursed for facility only” from 99487-99489
06/15/13	added CPT 22586 and mild procedure, CPT 92590-92596 now reimbursed
07/15/13	updated CPT 82150, E0781 reimbursed as of 7/1/13; CPT 90661 now reimbursed FDA approved as of 11/20/12
08/15/13	added CPT 80100, 80101 and 80104, no longer reimbursed effective 11/01/13
10/15/13	revised “C” codes that most codes will be reimbursed as of 01/01/14, added non-covered “C” codes to coding grid, updated reimbursement of influenza vaccines (CPT 90685-90688)
01/15/14	annual coding update
02/15/14	coding update; administrative edits
05/15/14	coding update; removed Category III CPT codes that deny provider liable from coding grid
08/15/14	updated reimbursement of CPT 90687 based on FDA approval 12/11/13
10/15/14	coding update; added new codes C9741, G0466-G0470 effective 10/01/14, added CPT 76390 as non-covered as of 01/01/15

01/01/15	annual coding update; removed codes deleted as of 12/31/14
05/15/15	updated CPT 22856, 22861, and 22864 — effective 07/01/15, reimbursed with prior authorization
07/15/15	updated A9274 reimbursed as of 02/01/15
01/15/16	annual coding update
02/15/16	updated CPT 43842 as no longer reimbursed as of 03/24/16, CPT 91112 no longer reimbursed as of 03/01/16
04/15/16	added link to biofeedback medical policy for CPT 90901, removed G0455 from coding grid, added CPT 99078
07/15/16	added CPT 92132, 86677, 52441, 52442 and 53855 as no longer reimbursed; added 99497 and 99498 reimbursed as of 01/01/16; removed “dry needling” from non-covered services section at end of coding table
09/15/16	added CPT 43754, 43755, and 82930
11/15/16	administrative edits
01/15/17	annual coding update
02/15/17	A0432 Reimbursed as of date of service 11/01/16, CPT 22858 now reimbursed w/prior authorization, as of date of service 04/01/17, CPT 43210 no longer reimbursed as of date of service 04/01/17
04/15/17	added CPT 31660/31661 reimbursed as of date of service 04/01/17 with prior authorization
05/15/17	added CPT 44705 reimbursed as of date of service 06/01/17
06/15/17	updated CPT 95800, 95801, 95806, G0398, G0400 reimbursed as of 09/01/17; updated CPT 93228-93229 reimbursed as of 07/01/17; updated 43843 no longer reimbursed as of 07/01/17; E0740 no longer reimbursed as of 07/15/17
11/15/17	updated CPT 77061, 77062 as a covered service as of 01/01/18; CPT 77063 and G0279 will be included in the allowance of another service as of 1/1/2018 date of service
01/02/18	updated molecular procedure codes reimbursed as of 03/01/18 when medically necessary after prior authorization
02/01/18	annual coding update
04/02/18	updated CPT 90750 FDA approved as of 10/20/17, CPT 90626 FDA approved as of 6/10/16, CPT 52441/52442 reimbursed as of 06/01/18
05/01/18	added CPT 64555, 64575, and 64585 no longer reimbursed as of 04/26/18
06/01/18	removed CPT code 15824-15828,15876, 21120-21139, 21270, 55970, 55980, 69300, as the codes are reimbursed when medically necessary after prior authorization; added 83993 as not reimbursed as of 08/01/18
07/01/18	updated CPT 92132 to reimbursed as of 07/01/18
09/04/18	added definitive drug testing billed using CPT codes not reimbursed as of date of service 11/01/18
11/01/18	removed date references, added G0513, G0514
02/01/19	annual coding update; updated CPT 74263 reimbursed as of 01/01/19
05/01/19	removed CPT 90739; added HCPCS L1812
06/03/19	added the following codes as not reimbursed as of date of service 08/01/19: CPT codes 22867, 33289, 58674, 93264 and HCPCS codes C1841, C1842, L8608
10/01/19	added G2012 not reimbursed effective 01/01/19
12/02/19	added quality measurement codes used in CMS’ Physician Voluntary Reporting Program
11/02/20	added CPT code 99072 as not separately reimbursed; administrative edits
02/01/21	annual coding update
05/01/21	removed 90697 and 90694
07/01/21	Added S1001 for clarity
09/01/21	added 99241-99245,99251-99255 no longer reimbursed as of data of service 11/1/2021