BlueCross BlueShield of New Mexico

Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered 2023 Commercial Benefit Procedure Code List

Posted February 2023

EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN. THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1. 2023.

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

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

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Consult the member benefit booklet or contact a customer service representative to determine coverage for a specific medical service or supply.

To make a request for a Recommended Clinical Review (Predetermination), refer to our Utilization Management information on our website. You can also submit a request through Availity. https://www.availity.com/

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.
	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).
Unlisted or Undefined	Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.

PRESS "CTRL" AND "F" KEYS AT THE SAME TIME TO BRING UP THE SEARCH BOX. ENTER A PROCEDURE CODE OR DESCRIPTION OF THE SERVICE.

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

Code	Code Description	Code Group & Description	Medical Policy No.	Medical Policy Title	Effective Date	Ending Date	Updates
00640	Anesth Spine Manipulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	_	_
00797	Anesth Surgery For Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_	_
11200	Removal Of Skin Tags <W/15	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
11201	Remove Skin Tags Add-On	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
11920	Correct Skin Color 6.0 Cm/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_	_
11921	Correct Skn Color 6.1-20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_	_
11922	Correct Skin Color Ea 20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_	_
11950	Tx Contour Defects 1 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	_	_	_
11951	Tx Contour Defects 1.1-5.0Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	_	_	_
11952	Tx Contour Defects 5.1-10Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	_	_	_
11954	Tx Contour Defects >10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	_	_	_
11960	Insert Tissue Expander(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
11970	Rplcmt Tiss Xpndr Perm Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.009 SUR716.001 SUR716.011	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_	_
11980	Implant Hormone Pellet(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RX501.063 SUR717.001 RX501.007 RX501.076	Compounded Drug Products Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies	_	_	_
15758	Free Fascial Flap Microvasc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR701.024	Surgery for Lipedema and Lymphedema	_	_	_
15769	Grfg Autol Soft Tiss Dir Exc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	_	_	_
15771	Grfg Autol Fat Lipo 50 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	_	_	_

15772	Grfg Autol Fat Lipo Ea Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	–	–	–
15775	Hair Trnspl 1-15 Punch Grfts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
15776	Hair Trnspl >15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
15780	Dermabrasion Total Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15781	Dermabrasion Segmental Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15782	Dermabrasion Other Than Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15783	Dermabrasion Suprfl Any Site	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15786	Abrasion Lesion Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15787	Abrasion Lesions Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15788	Chemical Peel Face Epiderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15789	Chemical Peel Face Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15792	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15793	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	–	–	–
15820	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15821	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15822	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15823	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15824	Removal Of Forehead Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR716.001 SUR717.001 SUR712.031	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Site:	–	–	–
15825	Removal Of Neck Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15826	Removal Of Brow Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR716.001 SUR717.001 SUR712.031	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Site:	–	–	–
15828	Removal Of Face Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
15829	Removal Of Skin Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
15830	Exc Skin Abd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15832	Excise Excessive Skin Thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15833	Excise Excessive Skin Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15834	Excise Excessive Skin Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15835	Excise Excessive Skin Buttck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15836	Excise Excessive Skin Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15837	Excise Excess Skin Arm/Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15838	Excise Excess Skin Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–

15839	Excise Excess Skin & Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024 SUR716.017	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema Surgical Treatment of Gynecomastia	–	–	–
15847	Exc Skin Abd Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001 SUR701.024	Cosmetic and Reconstructive Procedures Surgery for Lipedema and Lymphedema	–	–	–
15876	Suction Lipectomy Head&Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15877	Suction Lipectomy Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15878	Suction Lipectomy Upr Extrem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15879	Suction Lipectomy Lwr Extrem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	–	–	–
15999	Removal Of Pressure Sore	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
17106	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	–	–	–
17107	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	–	–	–
17108	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	–	–	–
17340	Cryotherapy Of Skin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE801.028	Acne Management	–	–	–
17360	Skin Peel Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.028	Acne Management	–	–	–
17380	Hair Removal By Electrolysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
17999	Skin Tissue Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	–	–	–
19300	Removal Of Breast Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.017	Surgical Treatment of Gynecomastia	–	–	–
19303	Mast Simple Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 SUR716.015	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Risk-Reducing (Prophylactic) Mastectomy	–	–	–
19316	Suspension Of Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR717.001 SUR716.010 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Mastopexy Reconstructive Breast Surgery	–	–	–
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR716.001 SUR717.001 SUR716.011 SUR716.012	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery Reduction Mammaplasty	–	–	–
19325	Breast Augmentation W/Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–	–
19328	Rmvl Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–	–
19330	Rmvl Ruptured Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–	–
19340	Insj Breast Implt Sm D Mast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.009 SUR717.001 SUR716.011	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–	–
19342	Insj/Rplcmt Brst Implt Sep D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.009 SUR717.001 SUR716.011	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–	–
19350	Breast Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–	–
19355	Correct Inverted Nipple(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
19357	Tiss Xpndr Plmt Brst Rcnstj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.011	Reconstructive Breast Surgery	–	–	–
19370	Revj Peri-Implt Capsule Brst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.011	Reconstructive Breast Surgery	–	–	–
19371	Peri-Implt Capslc Brst Compl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–	–
19499	Breast Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR716.021 SUR701.037 SUR701.031 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Reconstructive Breast Surgery	–	–	–
20527	Inj Dupuytren Cord W/Enzyme	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	–	–	–
20560	Ndl Insj W/O Njx 1 Or 2 Musc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	–	–	–
20561	Ndl Insj W/O Njx 3+ Musc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	–	–	–
20983	Ablate Bone Tumor(S) Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	–	–	–
20985	Cptr-Asst Dir Ms Px	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	–	–	–
20999	Musculoskeletal Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
21073	Mnpj Of Tmj W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016 SUR705.010	Manipulation Under Anesthesia Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–	–
21089	Prepare Face/Oral Prosthesis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–

21120	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21121	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21122	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21123	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21125	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery	_	_	_
21127	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR717.001 SUR705.030 SUR706.009	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Managemen	_	_	_
21145	Lefort I-1 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21146	Lefort I-2 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21147	Lefort I-3/> Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
21150	Lefort Ii Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21151	Lefort Ii W/Bone Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21154	Lefort Iii W/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21155	Lefort Iii W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21159	Lefort Iii W/Fhdw/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21160	Lefort Iii W/Fhd W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21188	Reconstruction Of Midface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21206	Reconstruct Upper Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21208	Augmentation Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21209	Reduction Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.030	Orthognathic Surgery	_	_	_
21248	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
21249	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
21299	Cranio/Maxillofacial Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
21499	Head Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
21685	Hyoid Myotomy & Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_	_
21899	Neck/Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
22505	Manipulation Of Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
22526	Idet Single Level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.023	Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty	_	_	_
22527	Idet 1 Or More Levels	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.023	Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty	_	_	_
22586	Prescrl Fuse W/ Instr L5-S1	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.038	Axial Lumbosacral Interbody Fusion	_	_	_
22867	Insj Stablj Dev W/Dcmprn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	_	_
22868	Insj Stablj Dev W/Dcmprn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	_	_
22869	Insj Stablj Dev W/O Dcmprn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	_	_
22870	Insj Stablj Dev W/O Dcmprn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	_	_
22899	Spine Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
22999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
23929	Shoulder Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.032	Shoulder Resurfacing	_	_	_
24300	Manipulate Elbow W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
24999	Upper Arm/Elbow Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_

25259	Manipulate Wrist W/Anesthes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
25999	Forearm Or Wrist Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
26340	Manipulate Finger W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
26341	Manipulat Palm Cord Post Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	_	_	_
26989	Hand/Finger Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
27275	Manipulation Of Hip Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
27280	Fusion Of Sacroiliac Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR705.033	Sacroiliac Joint Fusion or Stabilization	_	_	_
27299	Pelvis/Hip Joint Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR702.017 SUR705.019 SUR705.036 SUR705.029	Facet Joint and Sacroiliac Joint Denervation Hip Resurfacing (HR) Surgery for Groin Pain in Athletes Surgical Treatment of Femoroacetabular Impingement (FAI)	_	_	_
27599	Leg Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
27703	Reconstruction Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR705.021	Total Ankle Replacement (TAR)	_	_	_
27860	Fixation Of Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.016	Manipulation Under Anesthesia	_	_	_
27899	Leg/Ankle Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
28890	Hi Enrgy Eswt Plantar Fascia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_	_
28899	Foot/Toes Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
29440	Addition Of Walker To Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
29799	Casting/Strapping Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
29866	Autgrft Implnt Knee W/Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR705.020 SUR705.035	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	_	_	_
29914	Hip Arthro W/Femoroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	_	_	_
29915	Hip Arthro Acetabuloplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	_	_	_
29916	Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	_	_	_
29999	Arthroscopy Of Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.029 SUR705.041 SUR705.024	Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	_	_	_
30468	Rpr Nsl Vlv Collapse W/Implt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.017	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	_	_	_
30469	RPR NSL VLV COLLAPSE W/RMDLG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.001	Nasal and Sinus Surgery	_	_	_
30999	Nasal Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SUR706.001	_	_	_	_
31299	Sinus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SUR706.019 SUR706.001	_	_	_	_
31599	Larynx Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
31899	Airways Surgical Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
32994	Ablate Pulm Tumor Perq Crybl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	_	_
32998	Ablate Pulm Tumor Perq Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Live	_	_	_
32999	Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
33211	Insert Card Electrodes Dual	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	_	_	_
33267	EXCL LAA OPEN ANY METHOD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillatior	_	_	_
33268	EXCL LAA OTH PX ANY METH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillatior	_	_	_
33269	EXCL LAA THRSCP ANY METHOD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillatior	_	_	_
33274	Tcat Insj/Rpl Perm Ldls Pm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.030	Leadless Cardiac Pacemaker	_	_	_
33275	Tcat Rmvl Perm Ldls Pm W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.030	Leadless Cardiac Pacemaker	_	_	_
33285	Insj Subq Car Rhythm Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_	_
33418	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Transcatheter Mitral Valve Procedures	_	_	_
33419	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Transcatheter Mitral Valve Procedures	_	_	_
33542	Removal Of Heart Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.026	Cardiac Restoration and Remodeling Procedures	_	_	_
33999	Cardiac Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR707.026 SUR701.009 SUR703.027	Cardiac Restoration and Remodeling Procedures Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	_	_	_
36299	Vessel Injection Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
36465	Njx Noncmpnd Sclrsnt 1 Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
36466	Njx Noncmpnd Sclrsnt Mlt Vn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
36468	Njx Sclrsnt Spider Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
36470	Njx Sclrsnt 1 Incmptnt Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
36471	Njx Sclrsnt Mlt Incmptnt Vn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
36473	Endovenous Mchnchem 1St Vein	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	_	_	_

36474	Endovenous Mchnchem Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	–	–	–
36475	Endovenous Rf 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36476	Endovenous Rf Vein Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36478	Endovenous Laser 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36479	Endovenous Laser Vein Addon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36482	Endoven Ther Chem Adhes 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36483	Endoven Ther Chem Adhes Sbsq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
36516	Apheresis Immunoads Slctv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	THE802.003	Lipid Apheresis	–	–	–
36836	PRQ AV FSTL CRTJ UXTR 1 ACS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.047	Percutaneous Arteriovenous Fistula	–	–	–
36837	PRQ AV FSTL CRT UXTR SEP ACS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.047	Percutaneous Arteriovenous Fistula	–	–	–
37215	Transcath Stent Cca W/Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–	–
37216	Transcath Stent Cca W/O Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–	–
37217	Stent Placemt Retro Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–	–
37218	Stent Placemt Ante Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–	–
37241	Vasc Embolize/Occlude Venous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–	–
37242	Vasc Embolize/Occlude Artery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–	–
37243	Vasc Embolize/Occlude Organ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RAD601.047 SUR701.015 THE801.022	Radioembolization for Primary and Metastatic Tumors of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions Transcatheter Arterial Chemoembolization (TACE) of the Liver	–	–	–
37244	Vasc Embolize/Occlude Bleed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–	–
37500	Endoscopy Ligate Perf Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37501	Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
37700	Revise Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37718	Ligate/Strip Short Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37722	Ligate/Strip Long Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37735	Removal Of Leg Veins/Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37760	Ligate Leg Veins Radical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37761	Ligate Leg Veins Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37765	Stab Phleb Veins Xtr 10-20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37766	Phleb Veins - Extrem 20+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37780	Revision Of Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37785	Ligate/Divide/Excise Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	–	–	–
37799	Vascular Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
38129	Laparoscope Proc Spleen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
38204	Bl Donor Search Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38205	Harvest Allogeneic Stem Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38206	Harvest Auto Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38207	Cryopreserve Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38208	Thaw Preserved Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38209	Wash Harvest Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38210	T-Cell Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38211	Tumor Cell Deplete Of Harvst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38212	Rbc Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38213	Platelet Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38214	Volume Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38215	Harvest Stem Cell Concentrte	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38230	Bone Marrow Harvest Allogen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38232	Bone Marrow Harvest Autolog	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38240	Transplt Allo Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–
38241	Transplt Autol Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–	–

38242	Transplt Allo Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_
38243	Transplj Hematopoietic Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_
38308	Incision Of Lymph Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.024	Surgery for Lipedema and Lymphedema	_	_	_
38589	Laparoscope Proc Lymphatic	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
38999	Blood/Lymph System Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
39499	Chest Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
39599	Diaphragm Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
40799	Lip Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
40899	Mouth Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
41530	Tongue Base Vol Reduction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.021 SUR706.009	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver Sleep Related Breathing Disorders: Surgical Management	_	_	_
41599	Tongue And Mouth Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
41820	Excision Gum Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41821	Excision Of Gum Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41822	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41823	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41828	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41830	Removal Of Gum Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41870	Gum Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41872	Repair Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41874	Repair Tooth Socket	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
41899	Dental Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
42299	Palate/Uvula Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
42699	Salivary Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_

42999	Throat Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
43206	Esoph Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–	–
43236	Uppr Gi Scope W/Submuc Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.003 RX501.019 MED201.016	Bariatric Surgery Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD	–	–	–
43252	Egd Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–	–
43284	Laps Esophgl Sphnctr Agmntj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)	–	–	–
43289	Laparoscope Proc Esoph	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	–	–	–
43290	EGD FLX TRNSORL DPLMNT BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR716.003	Bariatric Surgery	–	–	–
43291	EGD FLX TRNSORL RMVL BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR716.003	Bariatric Surgery	–	–	–
43499	Esophagus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.016 SUR709.033	–	–	–	–
43633	Removal Of Stomach Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43644	Lap Gastric Bypass/Roux-En-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43645	Lap Gastr Bypass Incl Smll I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43659	Laparoscope Proc Stom	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
43770	Lap Place Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43771	Lap Revise Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43772	Lap Rmvl Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43773	Lap Replace Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43774	Lap Rmvl Gastr Adj All Parts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43775	Lap Sleeve Gastrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43842	V-Band Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43843	Gastroplasty W/O V-Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43845	Gastroplasty Duodenal Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43846	Gastric Bypass For Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43847	Gastric Bypass Incl Small I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43848	Revision Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43886	Revise Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43887	Remove Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43888	Change Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	–	–	–
43999	Stomach Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
44238	Laparoscope Proc Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
44799	Unlisted Px Small Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
44899	Bowel Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
44979	Laparoscope Proc App	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
45399	Unlisted Procedure Colon	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
45499	Laparoscope Proc Rectum	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
45999	Rectum Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
46707	Repair Anorectal Fist W/Plug	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR709.032	Plugs for Fistula Repair	–	–	–
46999	Anus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
47370	Laparo Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	–	–	–
47379	Laparoscope Procedure Liver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
47380	Open Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	–	–	–
47382	Percut Ablate Liver Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR701.038 SUR709.029	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	–	–	–
47399	Liver Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
47579	Laparoscope Proc Biliary	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
47999	Bile Tract Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
48999	Pancreas Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
49329	Laparo Proc Abdm/Per/Oment	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
49659	Laparo Proc Hernia Repair	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
49999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
50250	Cryoablate Renal Mass Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	–	–	–
50360	Transplantation Of Kidney	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.007 SUR703.008 SUR703.013	Kidney Transplant Liver Transplant and Combined Liver-Kidney Transplant Pancreas and Related Organ Tissue Transplantatior	–	–	–
50549	Laparoscope Proc Renal	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
50592	Perc Rf Ablate Renal Tumor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Live	–	–	–
50593	Perc Cryo Ablate Renal Tum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	–	–	–

50949	Laparoscope Proc Ureter	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
51715	Endoscopic Injection/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	–	–	–
51999	Laparoscope Proc Bla	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
52327	Cystoscopy Inject Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.022	Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	–	–	–
52441	Cystourethro W/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.023	Prostatic Urethral Lift	–	–	–
52442	Cystourethro W/Addl Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.023	Prostatic Urethral Lift	–	–	–
53855	Insert Prost Urethral Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.025	Temporary Prostatic Stent	–	–	–
53860	Transurethral Rf Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	–	–	–
53899	Urology Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
54125	Removal Of Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
54200	Treatment Of Penis Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54205	Treatment Of Penis Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54235	Penile Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54400	Insert Semi-Rigid Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54401	Insert Self-Contd Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54405	Insert Multi-Comp Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
54660	Revision Of Testis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
54699	Laparoscope Proc Testis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
55559	Laparo Proc Spermatic Cord	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
55880	Abltj Mal Prst8 Tiss Hifu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer	–	–	–
55899	Genital Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR717.014 SUR701.031 SUR710.019	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Nerve Graft With Radical Prostatectomy	–	–	–
55970	Sex Transformation M To F	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
55980	Sex Transformation F To M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
56805	Repair Clitoris	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
56810	Repair Of Perineum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
57291	Construction Of Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
57292	Construct Vagina With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
57335	Repair Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatmen!	–	–	–
57426	Revise Prosth Vag Graft Lap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–	–
58578	Laparo Proc Uterus	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
58579	Hysteroscope Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
58679	Laparo Proc Oviduct-Ovary	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
58999	Genital Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
59074	FETAL FLUID DRAINAGE W/US	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	–	–	–
59897	Fetal Invas Px W/Us	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	–	–	–
59898	Laparo Proc Ob Care/Deliver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
59899	Maternity Care Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
60659	Laparo Proc Endocrine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
60699	ENDOCRINE SURGERY PROCEDURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.031	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	–	–	–
61630	Intracranial Angioplasty	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.064 SUR701.027	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–	–
61635	Intracran Angioplsty W/Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.064 SUR701.027	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–	–
61650	Evasc Prlng Admn Rx Agnt 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–	–
61651	Evasc Prlng Admn Rx Agnt Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–	–
62263	Epidural Lysis Mult Sessions	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.024	Lysis of Epidural Adhesions	–	–	–
62264	Epidural Lysis On Single Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.024	Lysis of Epidural Adhesions	–	–	–
62287	Percutaneous Diskectomy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.004 SUR712.037	Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)	–	–	–
64582	Opn Mpltj Hpglsl Nstm Ary Pg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	–	–	–

64628	Trml Dstrj Ios Bvn 1St 2 L/S	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	–	–	–
64629	Trml Dstrj Ios Bvn Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	–	–	–
64640	Injection Treatment Of Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR705.040	Ablation of Peripheral Nerves to Treat Pain	–	–	–
64999	Nervous System Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RX501.019 SUR703.003 SUR702.017 SUR712.024 SUR701.031 MED205.037 SUR710.019 SUR712.033 MED205.032 MED205.035 MED205.036 MED205.039 MED201.039	Botulinum Toxin Brain Tissue Transplantation and Neurotransplantation Facet Joint and Sacroiliac Joint Denervation Lysis of Epidural Adhesions Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Navigated Transcranial Magnetic Stimulation (nTMS) Nerve Graft With Radical Prostatectomy Occipital Nerve Stimulation Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy Percutaneous Tibial Nerve Stimulation (PTNS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Sphenopalatine Ganglion Block for Headaches or Facial Pain Tumor Treating Fields (TTF) Therapy	–	–	–
65760	Revision Of Cornea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
65770	Revise Cornea With Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.030	Keratoprosthesis	–	–	–
65785	Impltj Ntrstrml Crnl Rng Seg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.031	Implantation of Intrastromal Corneal Ring Segments	–	–	–
66174	Translum Dil Eye Canal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.032	Viscocanalostomy and Canaloplasty	–	–	–
66175	Trnslum Dil Eye Canal W/Stnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.032	Viscocanalostomy and Canaloplasty	–	–	–
66179	Aqueous Shunt Eye W/O Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	–
66180	Aqueous Shunt Eye W/Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	–
66183	Insert Ant Drainage Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	–
66989	Xcpsl Ctrc Rmvl Cplx Insj 1+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	–
66991	Xcapsl Ctrc Rmvl Insj 1+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	–
66999	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
67299	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
67399	Unlisted Px Extraocular Musc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
67599	Orbit Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
67900	Repair Brow Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR716.004 SUR712.031	Blepharoplasty, Blepharoptosis and Brow Repair Surgical Deactivation of Headache Trigger Sites	–	–	–
67901	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67902	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67903	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67904	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67906	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67908	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	–	–	–
67999	Revision Of Eyelid	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
68399	Eyelid Lining Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
68899	Tear Duct System Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
69090	Pierce Earlobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
69300	Revise External Ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	–	–	–
69399	Outer Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
69705	Nps Surg Dilat Eust Tube Uni	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR706.018	Balloon Dilation of the Eustachian Tube	–	–	–
69706	Nps Surg Dilat Eust Tube Bi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR706.018	Balloon Dilation of the Eustachian Tube	–	–	–
69714	Implant Temple Bone W/Stimul	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	–	–
69716	IMPL OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	–	–
69717	Temple Bone Implant Revision	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	–	–
69719	RPLCM OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	–	–
69728	RMV NTR OI IMP SK TC>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	–	–	–
69730	RPLC OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	–	–	–
69799	Middle Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
69930	Implant Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	–	–	–
69949	Inner Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
69979	Temporal Bone Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
76496	Fluoroscopic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
76497	Ct Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
76498	Mri Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
76499	Radiographic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
76999	Echo Examination Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–

77299	Radiation Therapy Planning	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
77399	External Radiation Dosimetry	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
77499	Radiation Therapy Management	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
77799	Radium/Radioisotope Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78099	Endocrine Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78199	Blood/Lymph Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78299	Gi Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78399	Musculoskeletal Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78499	Cardiovascular Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78599	Respiratory Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78699	Nervous System Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78799	Genitourinary Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
78999	Nuclear Diagnostic Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
79999	Nuclear Medicine Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
80299	Quantitative Assay Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
81099	Urinalysis Test Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
81479	Unlisted Molecular Pathology	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MED208.089	–	–	–	–
81599	Unlisted Maaa	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
82523	Collagen Crosslinks	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	–	–	–
83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.158	Molecular Testing For Chronic Heart Failure and Heart Transplant	–	–	–
83695	Assay Of Lipoprotein(A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–	–
83698	Assay Lipoprotein Pla2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	–	–	–
83701	Lipoprotein Bld Hr Fraction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–	–
83704	Lipoprotein Bld Quan Part	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–	–
83722	Lipoprtn Dir Meas Sd Ldl Chl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–	–
83937	Assay Of Osteocalcin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	–	–	–
83987	Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.024	Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders	–	–	–
84112	Eval Amniotic Fluid Protein	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	–	–	–
84431	Thromboxane Urine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.148	Measurement of Thromboxane Metabolites in Urine	–	–	–
84999	Clinical Chemistry Test	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
85999	Hematology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
86001	Allergen Specific Igg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001	Allergy Management	–	–	–
86343	Leukocyte Histamine Release	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001	Allergy Management	–	–	–
86352	Cell Function Assay W/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.147	Immune Cellular Function Assay to Monitor and Predict Immune Function	–	–	–
86353	Lymphocyte Transformation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.088	Intracellular Micronutrient Analysis	–	–	–
86486	Skin Test Nos Antigen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
86849	Immunology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
86910	Blood Typing Paternity Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
86911	Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–

86950	Leukacyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_
86999	Transfusion Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
87505	Nfct Agent Detection Gi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.155	Gastrointestinal Panels	_	_	_
87506	Iadna-Dna/Rna Probe Tq 6-11	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.155	Gastrointestinal Panels	_	_	_
87507	Iadna-Dna/Rna Probe Tq 12-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED207.155	Gastrointestinal Panels	_	_	_
87797	Detect Agent Nos Dna Dir	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
87798	Detect Agent Nos Dna Amp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
87799	Detect Agent Nos Dna Quant	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
87899	Agent Nos Assay W/Optic	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
87999	Microbiology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
88000	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88005	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88007	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88012	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88014	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88016	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88020	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88025	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88027	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88028	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88029	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88036	Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88037	Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88040	Forensic Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88045	Coroners Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
88099	Necropsy (Autopsy) Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
88199	Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
88299	Cytogenetic Study	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
88375	Optical Endomicroscpy Interp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	_	_	_
88399	Surgical Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
88749	In Vivo Lab Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
89240	Pathology Lab Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
89258	Cryopreservation Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
89259	Cryopreservation Sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89335	Cryopreserve Testicular Tiss	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89337	Cryopreservation Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89342	Storage/Year Embryo(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89343	Storage/Year Sperm/Semen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89344	Storage/Year Reprod Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
89346	Storage/Year Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

89398	Unlisted Reprod Med Lab Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
90378	Rsv Mab Im 50Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	_	_	_
90399	Immune Globulin	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
90584	Dengue Vacc Quad 2 Dose Subq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
90689	Vacc liv4 No Prsrv 0.25Ml Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
90749	Vaccine Toxoid	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
90867	Tcranial Magn Stim Tx Plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	_	_	_
90868	Tcranial Magn Stim Tx Deli	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	_	_	_
90869	Tcran Magn Stim Redetemine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	_	_	_
90870	Electroconvulsive Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.013	Electroconvulsive Therapy	_	_	_
90875	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	_	_	_
90876	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	_	_	_
90880	Hypnotherapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
90885	Psy Evaluation Of Records	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
90889	Preparation Of Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
90899	Psychiatric Service/Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
90901	Biofeedback Train Any Meth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	_	_	_
90912	Bfb Training 1St 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.017 PSY301.016	Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence	_	_	_
90913	Bfb Training Ea Addl 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.017 PSY301.016	Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence	_	_	_
90999	Dialysis Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
91034	Gastroesophageal Reflux Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.005	Esophageal pH Monitoring	_	_	_
91035	G-Esoph Reflx Tst W/Electrod	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.005	Esophageal pH Monitoring	_	_	_
91037	Esoph Imped Function Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.005	Esophageal pH Monitoring	_	_	_
91038	Esoph Imped Funct Test > 1Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.005	Esophageal pH Monitoring	_	_	_
91065	Breath Hydrogen/Methane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.161	Hydrogen or Methane Breath Testing	_	_	_
91110	Gi Tract Capsule Endoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon	_	_	_
91111	Esophageal Capsule Endoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	_	_	_
91112	Gi Wireless Capsule Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_	_
91113	GI TRC IMG INTRAL COLON I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon	_	_	_
91117	Colon Motility 6 Hr Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_	_
91132	Electrogastrography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_	_
91133	Electrogastrography W/Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_	_
91299	Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
92015	Determine Refractive State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92065	Orthoptic/Pleoptic Training	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92132	Cmptr Ophth Dx Img Ant Segmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.021	Optical Coherence Tomography of the Anterior Eye Segment	_	_	_
92145	Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.031	Corneal Hysteresis	_	_	_
92340	Fit Spectacles Monofocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92341	Fit Spectacles Bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92342	Fit Spectacles Multifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92354	Fit Spectacles Single System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92355	Fit Spectacles Compound Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92370	Repair & Adjust Spectacles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
92499	Eye Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_

92512	Nasal Function Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED204.004	Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry	–	–	–
92517	Vemp Test I&R Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	–	–	–
92518	Vemp Test I&R Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	–	–	–
92519	Vemp Tst I&R Cervical&Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	–	–	–
92546	Sinusoidal Rotational Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.047	Vestibular Function Testing	–	–	–
92548	Cdp-Sot 6 Cond W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	–	–	–
92549	Cdp-Sot 6 Cond W/I&R Mct&Adt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	–	–	–
92640	Aud Brainstem Implt Programg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.009	Auditory Brainstem Implant	–	–	–
92700	Ent Procedure/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
93050	Art Pressure Waveform Analys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.070	Non-Invasive Measurement of Central Blood Pressure (cBP)	–	–	–
93228	Remote 30 Day Ecg Rev/Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	–	–	–
93229	Remote 30 Day Ecg Tech Supp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	–	–	–
93660	Tilt Table Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED202.048	Tilt Table Testing	–	–	–
93702	Bis Xtracell Fluid Analysis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.036	Bioimpedance Devices for Detection and Management of Lymphedema	–	–	–
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.014	Thermography	–	–	–
93797	Cardiac Rehab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.023	Cardiac Rehabilitation (CR)	–	–	–
93798	Cardiac Rehab/Monitor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.023	Cardiac Rehabilitation (CR)	–	–	–
93799	Cardiovascular Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
93998	Noninvas Vasc Dx Study Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
94014	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–	–
94015	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–	–
94016	Review Patient Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–	–
94452	Hast W/Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
94453	Hast W/Oxygen Titrate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
94799	Pulmonary Service/Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
95060	Eye Allergy Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	–	–	–
95065	Nose Allergy Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	–	–	–
95199	Allergy Immunology Services	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
95700	Eeg Cont Rec W/Vid Eeg Tech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95705	Eeg W/O Vid 2-12 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95706	Eeg Wo Vid 2-12Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95707	Eeg W/O Vid 2-12Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95709	Eeg W/O Vid Ea 12-26Hr Intmt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95710	Eeg W/O Vid Ea 12-26Hr Cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95711	Veeg 2-12 Hr Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95712	Veeg 2-12 Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95713	Veeg 2-12 Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95714	Veeg Ea 12-26 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95715	Veeg Ea 12-26Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95716	Veeg Ea 12-26Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95718	Eeg Phys/Qhp 2-12 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95719	Eeg Phys/Qhp Ea Incr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95720	Eeg Phy/Qhp Ea Incr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95721	Eeg Phy/Qhp>36<60 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95722	Eeg Phy/Qhp>36<60 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95724	Eeg Phy/Qhp>60<84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95725	Eeg Phy/Qhp>84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–

95726	Eeg Phy/Qhp>84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95803	Actigraphy Testing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.048	Actigraphy	–	–	–
95905	Motor &/ Sens Nrve Cndj Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033	Automated Point-of-Care Nerve Conduction Testing	–	–	–
95919	QUAN PUPLMTRY PHY/QHP UNI/BI	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.034	Autonomic Nervous System (ANS) Testing	–	–	–
95954	Eeg Monitoring/Giving Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–	–
95957	Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED205.008 MED205.040	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram Quantitative Electroencephalography (QEEG) as a Diagnostic Aid for Attention-Deficit Hyperactivity Disorder (ADHD)	–	–	–
95965	Meg Spontaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	–	–	–
95966	Meg Evoked Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	–	–	–
95967	Meg Evoked Each Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	–	–	–
95999	Neurological Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
96000	Motion Analysis Video/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.009	Gait Analysis	–	–	–
96001	Motion Test W/Ft Press Meas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.009	Gait Analysis	–	–	–
96002	Dynamic Surface Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE803.009 MED205.006	Gait Analysis Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	–	–	–
96003	Dynamic Fine Wire Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.009	Gait Analysis	–	–	–
96004	Phys Review Of Motion Tests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE803.009 MED205.006	Gait Analysis Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	–	–	–
96379	Ther/Prop/Diag Inj/Inf Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
96549	Chemotherapy Unspecified	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
96912	Photochemotherapy With Uv-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	–	–	–
96913	Photochemotherapy Uv-A Or B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	–	–	–
96922	Laser Tx Skin >500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.028 THE801.033	Acne Management Phototherapy for Dermatologic Conditions	–	–	–
96931	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96932	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96933	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96934	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96935	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96936	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	–	–	–
96999	Dermatological Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
97039	Physical Therapy Treatment	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	–	–	–	–	–
97139	Physical Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	–	–	–	–	–
97169	Athletic Trn Eval Low Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
97170	Athletic Trn Eval Mod Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
97171	Athletic Trn Eval High Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
97172	Athletic Trn Re-Eval Plan Cr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
97533	Sensory Integration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	PSY301.014 THE803.020	Autism Spectrum Disorders (ASD) Sensory Integration Therapy and Auditory Integration Therapy	–	–	–
97537	Community/Work Reintegration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services	–	–	–
97610	Low Frequency Non-Thermal Us	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.044	Ultrasound Wound Therapy	–	–	–
97799	Physical Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99024	Postop Follow-Up Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
99026	In-Hospital On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
99027	Out-Of-Hosp On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
99050	Medical Services After Hrs	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99056	Med Service Out Of Office	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99058	Office Emergency Care	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99070	Special Supplies Phys/Qhp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99071	Patient Education Materials	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	–
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	–	–	–
99078	Group Health Education	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99080	Special Reports Or Forms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	–	–	–
99082	Unusual Physician Travel	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
99183	Hyperbaric Oxygen Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	PSY301.014 THE801.003	Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy	–	–	–

99199	Special Service/Proc/Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
99360	Physician Standby Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99429	Unlisted Preventive Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
99446	Ntrprof Ph1/Ntrnet/Ehr 5-10	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99447	Ntrprof Ph1/Ntrnet/Ehr 11-20	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99448	Ntrprof Ph1/Ntrnet/Ehr 21-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99449	Ntrprof Ph1/Ntrnet/Ehr 31/>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99450	Basic Life Disability Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99451	Ntrprof Ph1/Ntrnet/Ehr 5/>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99452	Ntrprof Ph1/Ntrnet/Ehr Rfrl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99453	Rem Mntr Physiol Param Setup	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99454	Rem Mntr Physiol Param Dev	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99455	Work Related Disability Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99456	Disability Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99457	Rem Physiol Mntr 1St 20 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99491	Chrnc Care Mgmt Svc 30 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
99499	Unlisted E&M Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
99600	Home Visit Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
0052U	Lpoprtn Bld W/5 Maj Classes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	_	_	_
0054T	Bone Srgry Cmptr Fluor Image	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	_	_	_
0055T	Bone Srgry Cmptr Ct/Mri Imag	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	_	_	_
0062U	Ai Sle Igg&Igm Alys 80 Bmrk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.159	Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases	_	_	_
0063U	Neuro Autism 32 Amines Alg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014	Autism Spectrum Disorders (ASD)	_	_	_
0066U	Pamg-1 Ia Cervico-Vag Fluid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	_	_	_
0075T	Perq Stent/Chest Vert Art	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	_	_	_
0076T	S&I Stent/Chest Vert Art	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	_	_	_
0084U	Rbc Dna Gnotyp 10 Bld Groups	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0086U	Nfct Ds Bact&Fng Org Id 6+	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0087U	Crd Hrt Trnspl Mrna 1283 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0088U	Trnsplj Kdn Algrft Rej 1494	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0089U	Onc Mlnma Prame & Linc00518	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0090U	Onc Cutan Mlnma Mrna 23 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0091U	Onc Clrct Scr Whl Bld Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0092U	Onc Lng 3 Prtn Bmrk Plsm Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0093U	Rx Mntr 65 Com Drugs Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0094U	Genome Rapid Sequence Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0095U	Inflm Ee Elisa Alys Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0096U	Hpv Hi Risk Types Male Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0100T	Prosth Retina Receive&Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	_	_	_
0101T	Extracorp Shockwv Tx Hi Enrg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_	_
0101U	Hered Colon Ca Do 15 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0102T	Extracorp Shockwv Tx Anesth	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_	_
0102U	Hered Brst Ca Rltd Do 17 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0103U	Hered Ova Ca Pnl 24 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0105U	Neph Ckd Mult Eclia Tum Nec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0106T	Touch Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	_	_	_
0106U	Gstr Emptg 7 Timed Brth Spec	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_	_
0107T	Vibrate Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	_	_	_
0107U	C Diff Tox Ag Detcj Ia Stool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0108T	Cool Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	_	_	_
0108U	Gi Barrett Esoph 9 Prtn Bmrk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

0109T	Heat Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	_	_	_
0109U	Id Aspergillus Dna 4 Species	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0110T	Nos Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	_	_	_
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0111U	Onc Colon Ca Kras&Nras Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0112U	Iadi 16S&18S Rrna Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0113U	Onc Prst8 Pca3&Tmprss2-Erg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0114U	Gi Barretts Esoph Vim&Ccna1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0115U	Respir Iadna 18 Viral&2 Bact	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0116U	Rx Mntr Nzm Ia 35+Oral Flu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0117U	Pain Mgmt 11 Endogenous Anal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0118U	Trnsplj Don-Drv Cll-Fr Dna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0119U	Crd Ceramides Liq Chrom Plsm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0120U	Onc B Cll Lymphm Mrna 58 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0121U	Sc Dis Vcam-1 Whole Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0122U	Sc Dis P-Selectin Whl Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0123U	Mchnl Fragility Rbc Prflg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0129U	Hered Brst Ca Rltd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0130U	Hered Colon Ca Do Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0131U	Hered Brst Ca Rltd Do Pnl 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0132U	Hered Ova Ca Rltd Do Pnl 17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0133U	Hered Prst8 Ca Rltd Do 11	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0134U	Hered Pan Ca Mrna Pnl 18 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0135U	Hered Gyn Ca Mrna Pnl 12 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0136U	Atm Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0137U	Palb2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0138U	Brca1 Brca2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0140U	Nfct Ds Fungi Dna 15 Trgt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0141U	Nfct Ds Bact&Fng Gram Pos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0142U	Nfct Ds Bact&Fng Gram Neg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0143U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0144U	Drug Assay 160+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0145U	Drug Assay 65+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0146U	Drug Assay 80+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0147U	Drug Assay 85+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0148U	Drug Assay 100+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0149U	Drug Assay 60+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0150U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0152U	Nfct Ds Dna Untrgt Ngnrj Seq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
0153U	Onc Breast Mrna 101 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0154U	Onc Urthl Ca Rna Fgfr3 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0155U	Onc Brst Ca Dna Pik3Ca Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0156U	Copy Number Sequence Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0157U	Apc Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0158U	Mlh1 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0159U	Msh2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0160U	Msh6 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0161U	Pms2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0162U	Hered Colon Ca Trgt Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement	_	_	_	_	_
0198T	Ocular Blood Flow Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.022	Ophthalmologic Techniques For Evaluating Glaucoma	_	_	_
0202T	Post Vert Arthrplst 1 Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.034	Facet Arthroplasty	_	_	_
0207T	Clear Eyelid Gland W/Heat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	_	_	_
0219T	Plmt Post Facet Implt Cerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	_	_	_
0220T	Plmt Post Facet Implt Thor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	_	_	_

0221T	Plmt Post Facet Implt Lumb	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	_	_	_
0222T	Plmt Post Facet Implt Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	_	_	_
0232T	Njx Platelet Plasma	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_	_
0253T	Insert Aqueous Drain Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_	_
0263T	Im B1 Mrw Cel Ther Cmpl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	_	_	_
0264T	Im B1 Mrw Cel Ther Xcl Hrvst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	_	_	_
0265T	Im B1 Mrw Cel Ther Hrvst Onl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	_	_	_
0266T	IMPLT/RPL CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0267T	IMPLT/RPL CRTD SNS DEV LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0268T	Implt/Rpl Crtd Sns Dev Gen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0269T	REV/REMVL CRTD SNS DEV TOTAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0270T	REV/REMVL CRTD SNS DEV LEAD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0271T	REV/REMVL CRTD SNS DEV GEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0272T	Interrogate Crtd Sns Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0273T	INTERROGATE CRTD SNS W/PGRMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
0274T	Perq Lamot/Lam Crv/Thrc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.035	Image-Guided Minimally Invasive Decompression for Spinal Stenosis	_	_	_
0275T	Perq Lamot/Lam Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.035	Image-Guided Minimally Invasive Decompression for Spinal Stenosis	_	_	_
0278T	Tempr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	_	_	_
0330T	Tear Film Img Uni/Bi W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	_	_	_
0331T	Heart Symp Image Plnr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RAD604.012	Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure	_	_	_
0335T	Insj Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	_	_	_
0338T	Trnscth Renal Symp Denrv Unl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	_	_	_
0339T	Trnscth Renal Symp Denrv Bil	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	_	_	_
0345T	TRANSCATH MTRAL VLVE REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Transcatheter Mitral Valve Procedures	_	_	_
0347T	Ins Bone Device For Rsa	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	_	_	_
0348T	Rsa Spine Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	_	_	_
0349T	Rsa Upper Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	_	_	_
0350T	Rsa Lower Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	_	_	_
0352T	Oct Brst/Node I&R Per Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RAD601.053	Optical Coherence Tomography of the Breast	_	_	_
0354T	Oct Breast Surg Cavity I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RAD601.053	Optical Coherence Tomography of the Breast	_	_	_
0358T	Bia Whole Body	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.045	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA)	_	_	_
0378T	Visual Field Assmnt Rev/Rprt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	_	_	_
0379T	Vis Field Assmnt Tech Suppt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	_	_	_
0397T	Ercp W/Optical Endomicroscpy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	_	_	_
0398T	Mrgfus Strtctc Les Abltj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.022	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)	_	_	_
0424T	Insj/Rplc Nstim Apnea Compl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0425T	Insj/Rplc Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0426T	Insj/Rplc Nstim Apnea Stm Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0427T	Insj/Rplc Nstim Apnea Pls Gn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0428T	Rmvl Nstim Apnea Pls Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0429T	Rmvl Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0430T	Rmvl Nstim Apnea Stimj Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0431T	Rmvl/Rplc Nstim Apnea Pls Gn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_

0432T	Repos Nstim Apnea Stimj Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0433T	Repos Nstim Apnea Sensing Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0434T	Interro Eval Npgs Apnea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0435T	Prgrmg Eval Npgs Apnea 1 Ses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0436T	Prgrmg Eval Npgs Apnea Study	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
0449T	Insj Aqueous Drain Dev 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_	_
0450T	Insj Aqueous Drain Dev Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_	_
0464T	Visual Ep Test For Glaucoma	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.033	Visual Evoked Potential Testing for Glaucoma	_	_	_
0465T	Supchrdl Njx Rx W/O Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.035	Suprachoroidal Injection of a Pharmacologic Agent	_	_	_
0472T	Prgrmg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	_	_	_
0473T	Reprgrmg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	_	_	_
0474T	Insj Aqueous Drg Dev Io Rsvr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_	_
0479T	Fxjl Abl Lsr 1St 100 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
0480T	Fxjl Abl Lsr Ea Addl 100Sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
0483T	Tmvi Percutaneous Approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Transcatheter Mitral Valve Procedures	_	_	_
0484T	Tmvi Transthoracic Exposure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Transcatheter Mitral Valve Procedures	_	_	_
0485T	Oct Mid Ear I&R Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	_	_	_
0486T	Oct Mid Ear I&R Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	_	_	_
0499T	Cysto F/Urtl Strix/Stenosis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.026	Optilume (Drug Coated Balloon) for the Treatment of Urethral Stricture Conditions	_	_	_
0507T	Near Ifr 2Img Mibmn Glnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	_	_	_
0508T	Pls Echo Us B1 Dns Meas Tib	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.071	Pulse-Echo Ultrasound Bone Density Measurement	_	_	_
0509T	Pattern Erg W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.036	Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	_	_	_
0511T	Rmvl&Rinsj Sinus Tarsi Implt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	_	_	_
0512T	Esw Integ Wnd Hlg 1St Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_	_
0513T	Esw Integ Wnd Hlg Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_	_
0524T	Ev Cath Dir Chem Abltj W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
0533T	Cont Rec Mvmt Do 6-10 Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	_	_
0534T	Cont Rec Mvmt Do Setup&Train	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	_	_
0535T	Cont Rec Mvmt Do Reprt Cnfig	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	_	_
0536T	Cont Rec Mvmt Do Dl W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	_	_
0544T	TCAT MV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.025	Baroreflex Stimulation Devices	_	_	_
0563T	Evac Meibomian Glnd Heat Bi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	CPCP028	Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU)	_	_	_
0565T	Autol Cell Implt Adps Hrvg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	_	_	_
0566T	Autol Cell Implt Adps Njx	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	_	_	_
0587T	Perq Impltj/Rplcmt Isdns Ptn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	_	_	_
0588T	Revision/Removal Isdns Ptn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	_	_	_
0589T	Elec Alys Smpl Prgrmg Iins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	_	_	_
0590T	Elec Alys Cplx Prgrmg Iins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	_	_	_
0602T	Transdermal Gfr Measurements	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	_	_	_
0603T	Transdermal Gfr Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	_	_	_
0615T	Eye Mvmt Alys W/O Calbrj I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0620T	Evasc Ven Artlz Tibl/Prnl Vn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0621T	Trabeculostomy Interno Laser	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_

0622T	Trabeculostomy Int Lsr W/Scp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0623T	Auto Quantification C Plaque	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0624T	Auto Quan C Plaq Data Prep	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0625T	Auto Quan C Plaq Cptr Alys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0626T	Auto Quan C Plaq I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0627T	Perq Njx Algc Fluor Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0628T	Perq Njx Algc Fluor Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0629T	Perq Njx Algc Ct Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0630T	Perq Njx Algc Ct Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0631T	Tc Vis Lit Hyperspectral Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0632T	Perq Tcat Us Abltj Nrv P-Art	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0639T	Wrls Skn Snr Anisotropy Meas	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0640T	Ncntc Nr Ifr Spctrsc Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0641T	Ncntc Nr Ifr Spctrsc Wnd Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0642T	Ncntc Nr Ifr Spctrsc Wnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0643T	Tcat L Ventr Rstrj Dev Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0645T	Tcat Impltj C Sins Rdctj Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0646T	Ttvi/Rplcmt W/Prstc Vlv Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
0650T	Prgrmg Dev Eval Scrms Remote	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_	_
0651T	MAG CTRLD CAPSULE ENDOSCOPY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon	_	_	_
0656T	Vrt Bdy Tethering Ant <7 Seg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	_	_	_
0657T	Vrt Bdy Tethering Ant 8+ Seg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	_	_	_
0658T	Elec Impd Spectrsc 1+Skn Les	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	_	_	_
0664T	Don Hysterectomy Open Cdvr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0665T	Don Hysterectomy Open Liv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0666T	Don Hysterectomy Laps Liv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0667T	Don Hysterectomy Rcp Uter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0668T	Bkbench Prep Don Uter Algrft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0669T	Bkbench Rcnstj Don Uter Ven	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0670T	Bkbench Rcnstj Don Uter Artl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
0672T	NDOVAG CRYG RF REMDL TISS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	_	_	_
0743T	B1 STR & FX RSK VRT FX ASSMT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.033	Sacroiliac Joint Fixation/Fusion	_	_	_
0775T	ARTHRD SI JT PRQ IARTIC IMPL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	N/A	_	_	_
0783T	TC AURICULR NEUROSTIMULATION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	_	_	_
A0426	Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (Als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	ADM1001.005	Ambulance and Transport Services	_	_	_
A0430	Fixed Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.005	Ambulance and Medical Transport Services	_	_	_
A0431	Rotary Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.005	Ambulance and Medical Transport Services	_	_	_
A0435	Fixed Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.005	Ambulance and Medical Transport Services	_	_	_
A0436	Rotary Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.005	Ambulance and Medical Transport Services	_	_	_
A0888	Noncovered Ambulance Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.005	Ambulance and Medical Transport Services	_	_	_
A0999	Unlisted Ambulance Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A2001	Innovamatrix Ac Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_

A2002	Mirragen adv wnd mat per sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2004	Xcellistem per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2005	Microlyte matrix per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2006	Novosorb synpath per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2007	Restrata per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2008	Theragenesis per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2009	Symphony per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2010	Apis per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
A2011	Supra Sdrm Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	_	_	_
A2012	Suprathel Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	_	_	_
A2013	Innovamatrix Fs Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	_	_	_
A2014	Omeza collag per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	_	_
A2014	Omeza collag per 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2023	_
A2015	Phoenix wnd mtrx per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	_	_
A2015	Phoenix wnd mtrx per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2023	_
A2016	Permeaderm b per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	_	_
A2016	Permeaderm b per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2023	_
A2017	Permeaderm glove each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	_	_
A2017	Permeaderm glove each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2023	_
A2018	Permeaderm c per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	_	_
A2018	Permeaderm c per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2023	_
A4100	Skin Sub Fda Clrd As Dev Nos	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	_	_	_
A4335	Incontinence Supply	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A4421	Ostomy Supply Misc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A4458	Reusable Enema Bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4520	Incontinence Garment Anytype	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4553	Nondisp Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4554	Disposable Underpads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4555	Ca Tx E-Stim Electr/Transduc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.039	Tumor Treating Fields (TTF) Therapy	_	_	_
A4575	Hyperbaric O2 Chamber Disps	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014 THE801.003	Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy	_	_	_
A4596	Ces system monthly supp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	4/1/2023	_	_
A4596	Ces system monthly supp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	_	3/31/2023	_
A4600	Sleeve Inter Limb Comp Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
A4639	Infrared Ht Sys Replcmnt Pad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	_	_	_
A4641	Radiopharm Dx Agent Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A4649	Surgical Supplies	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A4890	Repair/Maint Cont Hemo Equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4913	Misc Dialysis Supplies Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A4927	Non-Sterile Gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4931	Reusable Oral Thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A4932	Reusable Rectal Thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A5507	Modification Diabetic Shoe	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A6000	Wound Warming Wound Cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	_	_	_
A6261	Wound Filler Gel/Paste /Oz	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A6262	Wound Filler Dry Form / Gram	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A6512	Compres Burn Garment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A6549	G Compression Stocking	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_

A9150	Misc/Exper Non-Prescript Dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A9152	Single Vitamin Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
A9153	Multi-Vitamin Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A9273	Hot/Cold Botle/Cap/Col/Wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A9279	Monitoring Feature/Devicenoc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9280	Alert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9282	Wig any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A9285	Inversion Eversion Cor Devic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.001	Orthotics	_	_	_
A9291	Pres Digital Behav Thera Fda	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY302.002	Digital Health Therapies for Substance Abuse	_	_	_
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
A9579	Gad-Base Mr Contrast Nos 1Ml	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9597	Pet Dx For Tumor Id Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9598	Pet Dx For Non-Tumor Id Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9698	Non-Rad Contrast Materialnoc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9699	Radiopharm Rx Agent Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9900	Supply/Accessory/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
A9999	Dme Supply Or Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
B9998	Enteral Supp Not Otherwise C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
B9999	Parenteral Supp Not Othrws C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
C1052	Hemostatic Agent Gi Topic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C1761	Cath Trans Intra Litho/Coro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C1764	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_	_
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR705.021 SUR705.024	Total Ankle Replacement (TAR) Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	_	_	_
C1783	Ocular Imp Aqueous Drain De	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_	_
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.030	Keratoprosthesis	_	_	_
C1823	Gen Neuro Trans Sen/Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	_	_	_
C1825	Gen Neuro Carot Sinus Baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.034	Baroreflex Stimulation Devices	_	_	_
C1833	Cardiac Monitor Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_	_
C1889	Implant/Insert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
C2624	Wireless Pressure Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	_	_	_
C2698	Brachytx Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
C2699	Brachytx Non-Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
C9257	Bevacizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	OTH903.020 OTH903.015	Bevacizumab for Ophthalmological Indications Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	_	_	_
C9354	Veritas Collagen Matrix Cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9356	Tenoglide Tendon Prot Cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9358	Dermal Substitute Native Non-Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9360	Surgimend Neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9363	Integra Meshed Bil Wound Mat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9364	Porcine Implant Permacol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
C9399	Unclassified Drugs Or Biologicals	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RX501.135 RX501.141 RX501.067 RX501.087 RX504.003 RX501.139 RX501.130 RX501.129	Casimersen Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders FDA-Approved Drugs and Biologicals Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Rethymic Veklury Viltolarsen	_	_	_
C9739	Cystoscopy Prostatic Imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.023	Prostatic Urethral Lift	_	_	_
C9740	Cysto Impl 4 Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR710.023	Prostatic Urethral Lift	_	_	_
C9757	Spine/Lumbar Disk Surgery	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.045	Annulus Closure After Discectomy	_	_	_
C9764	Revasc intravasc lithotripsy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_

C9765	Revasc intra lithotrip-stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9766	Revasc intra lithotrip-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9767	Revasc lithotrip-stent-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9768	Endo Us-Guide Hep Porto Grad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.043	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	_	_	_
C9769	Cysto W/Temp Pros Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.025	Temporary Prostatic Stent	_	_	_
C9770	Vitrectomy, Mechanical, Pars Plana Approach, With Subretinal Injection Of Pharmacologic/Biologic Agent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	_	_	_
C9771	Nsl/Sins Cryo Post Nasal Tis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.001	Nasal and Sinus Surgery	_	_	_
C9772	Revasc lithotrip tibi/perone	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9773	Revasc lithotr-stent tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9774	Revasc lithotr-ather tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9775	Revasc lith-sten-ath tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
C9777	Esophag Mucosal Integ Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	EIU Procedures/Services	_	_	_
C9898	Inpnt Stay Radiolabeled Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
C9899	Inpt Implant Pros Dev No Cov	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D0999	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D1705	AstraZeneca Covid-19 vaccine administration first dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D1706	AstraZeneca Covid-19 vaccine administration second dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D1999	Unspecified Preventive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D2999	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D3999	Unspecified Endodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D4999	Unspecified Periodontal Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D5899	Unspecified Removable Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D7210	Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D7999	Unspecified Oral Surgery Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D8210	Removable Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
D8999	Unspecified Orthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
D9999	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E0183	Press underlay alter w/pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.001 MED205.030	Hospital Beds and Related Equipment Quantitative Sensory Testing	_	_	_
E0210	Electric Heat Pad Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0217	Water Circ Heat Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0218	Fluid Circ Cold Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	_	_	_
E0231	Wound Warming Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	_	_	_
E0232	Warming Card For Nwt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	_	_	_
E0236	Pump For Water Circulating P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0240	Bath/Shower Chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0241	Bath Tub Wall Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0242	Bath Tub Rail Floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0243	Toilet Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0244	Toilet Seat Raised	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0247	Trans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

E0248	Hdtrans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0273	Bed Board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0274	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0300	Enclosed Ped Crib Hosp Grade	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.001	Hospital Beds and Related Equipment	_	_	_
E0315	Bed Accessory Brd/Tbl/Supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
E0316	Bed Safety Enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.001	Hospital Beds and Related Equipment	_	_	_
E0446	Topical Ox Deliver Sys Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E0485	Oral Device/Appliance Prefab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	_	_	_
E0486	Oral Device/Appliance Cusfab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	_	_	_
E0487	Electronic Spirometer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	_	_	_
E0616	Cardiac Event Recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_	_
E0625	Patient Lift Bathroom Or Toi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E0635	Patient Lift Electric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_	_
E0637	Combination Sit To Stand Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_	_
E0638	Standing Frame Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_	_
E0641	Multi-Position Stnd Fram Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_	_
E0642	Dynamic Standing Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_	_
E0650	Pneuma Compresor Non-Segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0651	Pneum Compressor Segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0652	Pneum Compres W/Cal Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0655	Pneumatic Appliance Half Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0656	Segmental Pneumatic Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0657	Segmental Pneumatic Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0660	Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0665	Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0666	Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0667	Seg Pneumatic Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0668	Seg Pneumatic Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0669	Seg Pneumatic Appli Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0670	Seg Pneum Int Legs/Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0671	Pressure Pneum Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0672	Pressure Pneum Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0673	Pressure Pneum Appl Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0675	Pneumatic Compression Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0676	Inter Limb Compress Dev Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_	_
E0691	Uvl Pnl 2 Sq Ft Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	_	_	_
E0692	Uvl Sys Panel 4 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	_	_	_
E0693	Uvl Sys Panel 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	_	_	_

E0694	Uvl Md Cabinet Sys 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.033	Phototherapy for Dermatologic Conditions	_	_	_
E0740	Non-Implant Pelv Flr E-Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.037 MED201.030	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence Sexual Dysfunctions, Assessment and Treatmen!	_	_	_
E0747	Elec Osteogen Stim Not Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR705.044	Electrical Bone Growth Stimulation of the Appendicular Skeleton	_	_	_
E0760	Osteogen Ultrasound Stimltor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.030	Low Intensity Pulsed Ultrasound Fracture Healing Device	_	_	_
E0761	Nontherm Electromgntc Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	_	_	_
E0762	Trans Elec Jt Stim Dev Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.042	Electrical Stimulation for the Treatment of Arthritis	_	_	_
E0764	Functional Neuromuscularstim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.033	Functional Neuromuscular Electrical Stimulation	_	_	_
E0766	Elec Stim Cancer Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.039	Tumor Treating Fields (TTF) Therapy	_	_	_
E0769	Electric Wound Treatment Dev	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	_	_	_
E0770	Functional Electric Stim Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.033	Functional Neuromuscular Electrical Stimulation	_	_	_
E0830	Ambulatory Traction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041	Pneumatic Traction and Spinal Unloading Devices	_	_	_
E0840	Tract Frame Attach Headboard	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0849	Cervical Pneum Trac Equip	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	_	_	_
E0850	Traction Stand Free Standing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0855	Cervical Traction Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0856	Cervic Collar W Air Bladders	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	_	_	_
E0860	Tract Equip Cervical Tract	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0890	Traction Frame Attach Pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0936	Cpm Device Other Than Knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.023	Continuous Passive Motion (CPM) Device	_	_	_
E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	_	_
E0985	W/C Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E0986	Man W/C Push-Rim Powr System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1002	Pwr Seat Tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1003	Pwr Seat Recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1004	Pwr Seat Recline Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1005	Pwr Seat Recline Pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1006	Pwr Seat Combo W/O Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1007	Pwr Seat Combo W/Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1008	Pwr Seat Combo Pwr Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1009	Add Mech Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1010	Add Pwr Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1012	Ctr Mount Pwr Elev Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1161	Manual Adult Wc W Tiltinspac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1229	Pediatric Wheelchair Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E1230	Power Operated Vehicle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E1239	Ped Power Wheelchair Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	_	_	_
E1399	Durable Medical Equipment Mi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E1629	Tablo For Dialysis Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	_	_
E1632	Wearable artificial kidney	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	_	_
E1699	Dialysis Equipment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
E1700	Jaw Motion Rehab System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
E1701	Repl Cushions For Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
E1702	Repl Measr Scales Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_	_
E2300	Pwr Seat Elevation Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2301	Pwr Standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_

E2310	Electro Connect Btw Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2311	Electro Connect Btw 2 Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2312	Mini-Prop Remote Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2313	Pwc Harness Expand Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2321	Hand Interface Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2322	Mult Mech Switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2323	Special Joystick Handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2324	Chin Cup Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2325	Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2326	Breath Tube Kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2327	Head Control Interface Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2328	Head/Extremity Control Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2329	Head Control Nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2330	Head Control Proximity Switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2331	Attendant Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2340	W/C Wdth 20-23 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2341	W/C Wdth 24-27 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2342	W/C Dpth 20-21 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2343	W/C Dpth 22-25 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2351	Electronic Sgd Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2373	Hand/Chin Ctrl Spec Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2374	Hand/Chin Ctrl Std Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2375	Non-Expandable Controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2376	Expandable Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2377	Expandable Controller Initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
E2500	Sgd Digitized Pre-Rec <=8Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2502	Sgd Prerec Msg >8Min <=20Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2504	Sgd Prerec Msg>20Min <=40Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2506	Sgd Prerec Msg > 40 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2508	Sgd Spelling Phys Contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2510	Sgd W Multi Methods Msg/Accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2511	Sgd Sftwre Prgrm For Pc/Pda	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2512	Sgd Accessory Mounting Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2599	Sgd Accessory Noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME104.009	Speech Generating Devices (SGD)	_	_	_
E2610	Powered W/C Cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
G0176	Opps/Php;Activity Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.014	Autism Spectrum Disorders (ASD)	_	_	_
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	AIM	AIM Guidelines	_	_	_
G0255	Current Percep Threshold Tst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033 MED205.030	Automated Point-of-Care Nerve Conduction Testing Quantitative Sensory Testing	_	_	_
G0276	Pild/Placebo Control Clin Tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	_	_	_
G0281	Elec Stim Unattend For Press	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	_	_	_
G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	_	_	_
G0293	Non-Cov Surg Proc Clin Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G0294	Non-Cov Proc Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G0295	Electromagnetic Therapy Onc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	_	_	_
G0329	Electromagntic Tx For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	_	_	_
G0341	Percutaneous Islet Celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_	_
G0342	Laparoscopy Islet Cell Trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_	_
G0343	Laparotomy Islet Cell Transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_	_
G0422	Intens Cardiac Rehab W/Exerc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.023	Cardiac Rehabilitation (CR)	_	_	_
G0423	Intens Cardiac Rehab No Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.023	Cardiac Rehabilitation (CR)	_	_	_
G0428	Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.034	Meniscal Allografts and Other Meniscal Implants	_	_	_

G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
G0460	Autologous Prp For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_	_
G0465	Autolog Prp Diab Wound Ulcer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_	_
G2011	Alcohol/Sub Misuse Assess	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G2082	Visit esketamine 56m or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.105	Esketamine Nasal Spray	_	_	_
G2083	Visit esketamine > 56m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.105	Esketamine Nasal Spray	_	_	_
G8395	Lvef>=40% Doc Normal Or Mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8396	Lvef Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8397	Dil Macula/Fundus Exam/W Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8399	Pt W/Dxa Results Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8400	Pt W/Dxa No Results Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8404	Low Extremity Neur Exam Docum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8405	Low Extremity Neur Not Perfor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8410	Eval On Foot Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8415	Eval On Foot Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8416	Pt Inelig Footwear Evaluatio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8417	Calc Bmi Abv Up Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8418	Calc Bmi Blw Low Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8419	Calc Bmi Out Nrm Param Nof/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8420	Calc Bmi Norm Parameters	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8421	Bmi Not Calculated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8427	Docrev Cur Meds By Elig Clin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8428	Cur Meds Not Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8430	Doc Med Rsn No Medrec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8431	Pos Clin Depres Scrn F/U Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8432	Dep Scr Not Doc Rng	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8433	Scr For Dep Not Cpt Doc Rsn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8450	Beta-Bloc Rx Pt W/Abn Lvef	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8451	Pt W/Abn Lvef Inelig B-Bloc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8452	Pt W/Abn Lvef B-Bloc No Rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8465	High Risk Recurrence Pro Ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8473	Ace/Arb Thxpy Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8474	Ace/Arb Not Rx'D; Doc Reas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8475	Ace/Arb Thxpy Not Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8476	Bp Sys <140 And Dias <90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8477	Bp Sys>=140 And/Or Dias >=90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8478	Bp Not Performed/Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8482	Flu Immunize Order/Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8483	Flu Imm No Admin Doc Rea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G8484	Flu Immunize No Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
G9050	Oncology Work-Up Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9051	Oncology Tx Decision-Mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9052	Onc Surveillance For Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9053	Onc Expectant Management Pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9054	Onc Supervision Palliative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9055	Onc Visit Unspecified Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
G9056	Onc Prac Mgmt Adheres Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9057	Onc Pract Mgmt Differs Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9058	Onc Prac Mgmt Disagree W/Gui	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9059	Onc Prac Mgmt Pt Opt Alterna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9060	Onc Prac Mgmt Dif Pt Comorb	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9061	Onc Prac Cond Noadd By Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9062	Onc Prac Guide Differs Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9063	Onc Dx Nsclc Stgi No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

G9064	Onc Dx Nsclc Stg2 No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9065	Onc Dx Nsclc Stg3A No Progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9066	Onc Dx Nsclc Stg3B-4 Metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9067	Onc Dx Nsclc Dx Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9068	Onc Dx Sclc/Nsclc Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9069	Onc Dx Sclc/Nsclc Ext At Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9070	Onc Dx Sclc/Nsclc Ext Unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9071	Onc Dx Brst Stg1-2B Hr Nopro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9072	Onc Dx Brst Stg1-2 Noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9073	Onc Dx Brst Stg3-Hr No Pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9074	Onc Dx Brst Stg3-Noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9075	Onc Dx Brst Metastic/ Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9077	Onc Dx Prostate T1No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9078	Onc Dx Prostate T2No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9079	Onc Dx Prostate T3B-T4Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9080	Onc Dx Prostate W/Rise Psa	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9083	Onc Dx Prostate Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9084	Onc Dx Colon T1-3 N1-2 No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9085	Onc Dx Colon T4 N0 W/O Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9086	Onc Dx Colon T1-4 No Dx Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9087	Onc Dx Colon Metas Evid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9088	Onc Dx Colon Metas Noevid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9089	Onc Dx Colon Extent Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9090	Onc Dx Rectal T1-2 No Progr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9091	Onc Dx Rectal T3 N0 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9092	Onc Dx Rectal T1-3 N1-2Noprg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9093	Onc Dx Rectal T4 N M0 No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9094	Onc Dx Rectal M1 W/Mets Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9095	Onc Dx Rectal Extent Unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9096	Onc Dx Esophag T1-T3 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9097	Onc Dx Esophageal T4 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9098	Onc Dx Esophageal Mets Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9099	Onc Dx Esophageal Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9100	Onc Dx Gastric No Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9101	Onc Dx Gastric P R1-R2Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9102	Onc Dx Gastric Unresectable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9103	Onc Dx Gastric Recurrent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9104	Onc Dx Gastric Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9105	Onc Dx Pancreatc P R0 Res No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9106	Onc Dx Pancreatc P R1/R2 No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9107	Onc Dx Pancreatic Unresectab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9108	Onc Dx Pancreatic Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9109	Onc Dx Head/Neck T1-T2No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9110	Onc Dx Head/Neck T3-4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9111	Onc Dx Head/Neck M1 Mets Rec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9112	Onc Dx Head/Neck Ext Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9113	Onc Dx Ovarian Stg1A-B No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9114	Onc Dx Ovarian Stg1A-B Or 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9115	Onc Dx Ovarian Stg3/4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9116	Onc Dx Ovarian Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9117	Onc Dx Ovarian Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9123	Onc Dx Cml Chronic Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9124	Onc Dx Cml Acceler Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9125	Onc Dx Cml Blast Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9126	Onc Dx Cml Remission	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9128	Onc Dx Multi Myeloma Stage I	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9129	Onc Dx Mult Myeloma Stg2 Hig	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9130	Onc Dx Multi Myeloma Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

G9131	Onc Dx Brst Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9132	Onc Dx Prostate Mets No Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9133	Onc Dx Prostate Clinical Met	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9134	Onc Nhlstg 1-2 No Relap No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9135	Onc Dx Nhl Stg 3-4 Not Relap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9136	Onc Dx Nhl Trans To Lg Bcell	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9137	Onc Dx Nhl Relapse/Refractor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9138	Onc Dx Nhl Stg Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9139	Onc Dx Cml Dx Status Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9140	Frontier Extended Stay Demo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous, By Any Means, Guided By The Results Of Measurements For:Respiratory Quotient; And/Or, Urine Urea Nitrogen (Uun); And/Or, Arterial, Venous Or Capillary Glucose; And/Or Potassium Concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	_	_	_
G9978	Remote E/M New Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9979	Remote E/M New Pt 20Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9980	Remote E/M New Pt 30 Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9981	Remote E/M New Pt 45Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9982	Remote E/M New Pt 60Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9983	Remote E/M Est. Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9984	Remote E/M Est. Pt 15Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9985	Remote E/M Est. Pt 25Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9986	Remote E/M Est. Pt 40Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
G9987	Bpci Advanced In Home Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
H0046	Mental Health Service Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
H0047	Alcohol/Drug Abuse Svc Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J0129	Abatacept Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.113 RX501.096	Abatacept Specialty Medication Administration Site of Care	_	_	_
J0172	Inj Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.137	Aducanumab-avwa	_	_	_
J0180	Agalsidase Beta Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_	_
J0202	Injection Alemtuzumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.077	Alemtuzumab	_	_	_
J0219	Inj Aval Alfa-Nqpt 4Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_	_
J0220	Alglucosidase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_	_
J0221	Injection Alglucosidase Alfa (Lumizyme) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_	_
J0222	Inj. Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.102	Specialty Medication Administration Site of Care Patisiran (Onpattro)	_	_	_
J0223	Inj Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.125 RX501.096	Givosiran Specialty Medication Administration Site of Care	_	_	_
J0224	Inj. Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.133	Lumasiran	_	_	_
J0256	Alpha 1 Proteinase Inhibitor	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J0490	Injection, Belimumab, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.116 RX501.096	Belimumab Specialty Medication Administration Site of Care	_	_	_
J0491	Inj Anifrolumab-Fnia 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.138	Anifrolumab-fnia	_	_	_
J0517	Inj. Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.100 RX501.096	Benralizumab Specialty Medication Administration Site of Care	_	_	_
J0565	Inj Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.093	Bezlotoxumab	_	_	_
J0567	Inj. Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.092	Cerliponase alfa	_	_	_
J0584	Injection Burosumab-Twza 1M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.058 RX501.096	Burosumab-twza Specialty Medication Administration Site of Care	_	_	_
J0586	Abobotulinumtoxina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	_	_	_
J0587	Inj Rimabotulinumtoxinb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	_	_	_
J0588	Injection, Incobotulinumtoxin A, 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	_	_	_
J0598	C-1 Esterase Cinryze	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.013 RX501.096	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide Specialty Medication Administration Site of Care	_	_	_
J0638	Canakinumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.119 RX501.096	Canakinumab Specialty Medication Administration Site of Care	_	_	_

J0717	Certolizumab Pegol Inj 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.111 RX501.096	Certolizumab Pegol Specialty Medication Administration Site of Care	–	–	–
J0775	Collagenase Clost Hist Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	–	–	–
J0791	Inj Crizanlizumab-Tmca 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.126 RX501.096	Crizanlizumab-tmca Specialty Medication Administration Site of Care	–	–	–
J0881	Darbepoetin Alfa Non-Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	–	–	–
J0888	Epoetin Beta Non Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	–	–	–
J1290	Ecallantide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.013 RX501.096	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide Specialty Medication Administration Site of Care	–	–	–
J1300	Eculizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.066 RX501.096	Eculizumab Specialty Medication Administration Site of Care	–	–	–
J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.095 RX501.096	Edaravone Specialty Medication Administration Site of Care	–	–	–
J1302	Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.087		–	–	–
J1303	Inj. Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.107 RX501.096	Ravulizumab-cwvz Specialty Medication Administration Site of Care	–	–	–
J1305	Inj evinacumab-dgnb 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.136	Evinacumab-dgnb	–	–	–
J1306	Injection inclisiran 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.142	Inclisiran	–	–	–
J1322	Elosulfase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	–
J1325	Epoprostenol Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	–	–	–
J1426	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.135	Casimersen	–	–	–
J1427	Vitolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.129	Viltolarsen	–	–	–
J1428	Inj Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.084	Eteplirsen	–	–	–
J1429	Inj Golodirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.122	Golodirsen	–	–	–
J1458	Galsulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	–
J1551	Inj cutaquig 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	–	–	–
J1554	Injection, Immune Globulin (Asceniv), 500Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	–	–	–
J1602	Golimumab For Iv Use 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.112 RX501.096	Golimumab Specialty Medication Administration Site of Care	–	–	–
J1632	Inj. Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.106	Brexanolone for Postpartum Depression	–	–	–
J1729	Inj Hydroxyprogst Capoat Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	–
J1743	Idursulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	–
J1745	Infliximab Not Biosimil 10Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	THE801.028 RX501.051 RX501.096	Acne Management Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	–	–	–
J1746	Inj. Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.099 RX501.096	Ibalizumab-uiyk Specialty Medication Administration Site of Care	–	–	–
J1786	Imuglucerase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	–
J1823	Inj. Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.127	Inebilizumab-cdon	–	–	–
J1931	Laronidase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	–
J1951	Inj Fensolvi 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	–	–	–
J2182	Injection Mepolizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.080 RX501.096	Mepolizumab Specialty Medication Administration Site of Care	–	–	–
J2278	Ziconotide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.060	Ziconotide	–	–	–
J2350	Injection Ocrelizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.085 RX501.096	Ocrelizumab Specialty Medication Administration Site of Care	–	–	–
J2356	Inj tezepelumab-ekko 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.143	Tezepelumab-ekko	–	–	–
J2357	Omalizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.058 RX501.096	Omalizumab Specialty Medication Administration Site of Care	–	–	–
J2440	Papaverin Hcl Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED201.030	Sexual Dysfunctions, Assessment and Treatment	–	–	–
J2502	Inj Pasireotide Long Acting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.079	Pasireotide	–	–	–
J2503	Pegaptanib Sodium Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	–	–	–
J2507	Injection Pegloticase 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.120 RX501.096	Pegloticase Specialty Medication Administration Site of Care	–	–	–
J2777	Inj faricimab-svoa 0.1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.044	Faricimab-svoa	–	–	–
J2778	Ranibizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	OTH903.015 OTH903.041	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) Ranibizumab Injections, Implants and Biosimilars	–	–	–
J2779	Inj susvimo 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	–	–	–
J2786	Injection Reslizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.083 RX501.096	Reslizumab Specialty Medication Administration Site of Care	–	–	–

J2840	Inj Sebelipase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	
J3032	Inj. Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.124 RX501.096	Eptinezumab-jjmr Specialty Medication Administration Site of Care	–	–	
J3060	Inj Taliglucerace Alfa 10 U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	
J3121	Inj Testostero Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Testosterone Replacement Therapies	–	–	
J3145	Testosterone Undecanoate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Testosterone Replacement Therapies	–	–	
J3241	Inj. Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.110	Specialty Medication Administration Site of Care Teprotumumab	–	–	
J3245	Inj. Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.123	Specialty Medication Administration Site of Care Tildrakizumab-asmn	–	–	
J3262	Tocilizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.115	Specialty Medication Administration Site of Care Tocilizumab	–	–	
J3285	Treprostinil Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	–	–	
J3316	Inj. Triptorelin Xr 3.75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RX501.041 RX501.040	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists Human Growth Hormone (GH)	–	–	
J3358	Ustekinumab Iv Inject 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.114	Specialty Medication Administration Site of Care Ustekinumab	–	–	
J3380	Injection Vedolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.096 RX501.117	Specialty Medication Administration Site of Care Vedolizumab	–	–	
J3385	Velaglucerase Alfa	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	
J3397	Inj. Vestronidase Alfa-Vjbk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	–	–	
J3398	Inj Luxturna 1 Billion Vec G	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	–	–	
J3399	Inj Onase Abepar-Xioi Treat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.104	Onasemnogene Abeparvovec-xioi	–	–	
J3490	Drugs Unclassified Injection	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MED206.001 RX501.135 RX501.063 SUR716.001 RX501.141 RX501.067 RX501.105 RX501.087 RX501.040 RX504.003 RX501.080 SUR706.001 RX501.086 RX501.085 RX501.104 RX501.139 RX502.030 MED206.006 MED201.014 RX501.130 RX501.129 RX501.049	Allergy Management Casimersen Compounded Drug Products Cosmetic and Reconstructive Procedures Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders Esketamine Nasal Spray FDA-Approved Drugs and Biologicals Human Growth Hormone (GH) Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Mepolizumab Nasal and Sinus Surgery Nusinersen Ocrelizumab Onasemnogene Abeparvovec-xioi Rethymic Rituximab and Biosimilars for Non-Oncologic Indications Sublingual Immunotherapy as a Technique of Allergen-Specific Therapy Treatment of Hyperhidrosis Veklury Viltolarsen Viscosupplementation for Osteoarthritis	–	–	
J3520	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.008	Chelation Therapy	–	–	
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–	
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RX501.135 RX501.073 RX501.063 RX501.141 RX501.067 RX501.087 RX504.003 RX501.051 RX501.080 RX501.085 RX501.104 RX501.139 RX501.129	Casimersen Clostridial Collagenase for Fibroproliferative Disorders Compounded Drug Products Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders FDA-Approved Drugs and Biologicals Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Infliximab and Associated Biosimilars Mepolizumab Ocrelizumab Onasemnogene Abeparvovec-xioi Rethymic Viltolarsen	–	–	
J3591	Esrd On Dialysi Drug/Bio Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
J7177	Inj. Fibryga 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	–	–	
J7178	Inj Human Fibrinogen Con Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	–	–	
J7192	Factor Viii Recombinant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
J7195	Factor Ix Recombinant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
J7199	Hemophilia Clot Factor Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
J7309	Methyl Aminolevulinate Top	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.027	Dermatologic Applications of Photodynamic Therapy (PDT)	–	–	
J7316	Inj Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.026	Ocriplasmin for Symptomatic Vitreomacular Adhesion	–	–	
J7340	Carbidopa Levodopa Ent 100Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX504.015	Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease.	–	–	
J7402	Mometasone Sinus Sinuva	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR706.001	Nasal and Sinus Surgery	–	–	
J7599	Immunosuppressive Drug Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	

J7604	Acetylcysteine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7607	Levalbuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7609	Albuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7610	Albuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7615	Levalbuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7622	Beclomethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7624	Betamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7627	Budesonide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7628	Bitolterol Mesylate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7629	Bitolterol Mesylate Comp Unt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7632	Cromolyn Sodium Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7634	Budesonide Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7635	Atropine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7636	Atropine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7637	Dexamethasone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7638	Dexamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7640	Formoterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7641	Flunisolide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7642	Glycopyrrolate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7643	Glycopyrrolate Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7645	Ipratropium Bromide Comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7647	Isoetharine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7650	Isoetharine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7657	Isoproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7660	Isoproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7667	Metaproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7670	Metaproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7676	Pentamidine Comp Unit Dose	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7680	Terbutaline Sulf Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7681	Terbutaline Sulf Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7683	Triamcinolone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7684	Triamcinolone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7685	Tobramycin Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	_	_	_
J7699	Inhalation Solution For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J7799	Non-Inhalation Drug For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J7999	Compounded Drug Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J8498	Antiemetic Rectal/Supp Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J8499	Oral Prescrip Drug Non Chemo	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J8597	Antiemetic Drug Oral Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J8999	Oral Prescription Drug Chemo	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J9020	Asparaginase Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
J9285	Inj Olaratumab 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

J9332	Inj efgartigimod 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.141	Efgartigimod alfa-fcab	_	_	_
J9600	Porfimer Sodium Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE801.029	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus	_	_	_
J9999	Chemotherapy Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MED203.002 RX501.063 RX501.087 RX504.003 RX501.085 RX501.057	Antineoplaston Cancer Therapy Compounded Drug Products FDA-Approved Drugs and Biologicals Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Ocrelizumab Sodium Phenylbutyrate	_	_	_
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0010	Stnd Wt Frame Power Whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0011	Stnd Wt Pwr Whlchr W Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0012	Ltwt Portbl Power Whlchr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0013	Custom Power Whlchr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0014	Other Power Whlchr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0053	Elevate Footrest Articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0065	Spoke Protectors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0108	W/C Component-Accessory Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	_	_	_
K0455	Pump Uninterrupted Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	_	_
K0800	Pov Group 1 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0801	Pov Group 1 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0802	Pov Group 1 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0806	Pov Group 2 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0807	Pov Group 2 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0808	Pov Group 2 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0812	Power Operated Vehicle Noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	_	_	_
K0813	Pwc Gp 1 Std Port Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0814	Pwc Gp 1 Std Port Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0815	Pwc Gp 1 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0816	Pwc Gp 1 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0820	Pwc Gp 2 Std Port Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0821	Pwc Gp 2 Std Port Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0822	Pwc Gp 2 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0823	Pwc Gp 2 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0824	Pwc Gp 2 Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0825	Pwc Gp 2 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0826	Pwc Gp 2 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0827	Pwc Gp Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0828	Pwc Gp 2 Xtra Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0829	Pwc Gp 2 Xtra Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0830	Pwc Gp2 Std Seat Elevate S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0831	Pwc Gp2 Std Seat Elevate Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0835	Pwc Gp2 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0836	Pwc Gp2 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0837	Pwc Gp 2 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0838	Pwc Gp 2 Hd Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0839	Pwc Gp2 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0840	Pwc Gp2 Xhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0841	Pwc Gp2 Std Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0842	Pwc Gp2 Std Mult Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0843	Pwc Gp2 Hd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0848	Pwc Gp 3 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0849	Pwc Gp 3 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0850	Pwc Gp 3 Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0851	Pwc Gp 3 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0852	Pwc Gp 3 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0853	Pwc Gp 3 Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0854	Pwc Gp 3 Xhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0855	Pwc Gp 3 Xhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0856	Pwc Gp3 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_

K0857	Pwc Gp3 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0858	Pwc Gp3 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0859	Pwc Gp3 Hd Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0860	Pwc Gp3 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0861	Pwc Gp3 Std Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0862	Pwc Gp3 Hd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0863	Pwc Gp3 Vhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0864	Pwc Gp3 Xhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0868	Pwc Gp 4 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0869	Pwc Gp 4 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0870	Pwc Gp 4 Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0871	Pwc Gp 4 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0877	Pwc Gp4 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0878	Pwc Gp4 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0879	Pwc Gp4 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0880	Pwc Gp4 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0884	Pwc Gp4 Std Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0885	Pwc Gp4 Std Mult Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0886	Pwc Gp4 Hd Mult Pow S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0890	Pwc Gp5 Ped Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0891	Pwc Gp5 Ped Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K0898	Power Wheelchair Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
K0899	Pow Mobil Dev No Dmepdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME101.010	Wheelchairs and Accessories	_	_	_
K1002	Ces System W/Supplies Access	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	_	_	_
K1003	Whirlpool Tub Walkin Portabl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
K1004	Lo Freq Us Diathermy Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.008	Non-Covered Physical Therapy Services	_	_	_
K1007	Bil Hkaf Pc S/D Micro Sensor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.008	Powered Exoskeleton for Ambulation in Patients With Lower-Limb Disabilities	_	_	_
K1009	Speech Volume Modulation Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.014	Speech-Language Therapy (SLT)	_	_	_
K1018	Ext Up Limb Tremor Stim Wris	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1019	Monthly Supp Use With K1018	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1020	Non-Invasive Vagus Nerv Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR712.021	Vagus Nerve Stimulation (VNS)	_	_	_
K1023	Trans elec nerv periph nerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	_	_	_
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1025	Non pneum compress full arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1027	Oral dev without fix mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	_	_	_
K1030	Ext Recharge Bat Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	MED202.068	Cardiac Contractility Modulation (CCM) Device	_	_	_
K1031	Non Pneu Comp Control W/O Ca	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1032	Non Pneum Seq Comp Full Leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
K1033	Non Pneum Seq Comp Half Leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_	_
L0999	Add To Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L1499	Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L1844	Ko W/Adj Jt Rot Cntrl Molded	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME103.002	Knee Braces	_	_	_
L2006	Kaf Sng/Dbl Swg/Stn Mcpr Cus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
L2999	Lower Extremity Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L3040	Ft Arch Suprt Premold Longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
L3050	Foot Arch Supp Premold Metat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
L3060	Foot Arch Supp Longitud/Meta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
L3649	Orthopedic Shoe Modifica Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L3999	Upper Limb Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L5857	Elec Knee-Shin Swing Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	_	_
L5973	Ank-Foot Sys Dors-Plant Flex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	_	_
L5999	Lowr Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_

L6026	Part Hand Myo Exclu Term Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6611	Additional Switch Ext Power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6880	Electric Hand Switch Or Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6920	Wrist Disarticul Switch Ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6925	Wrist Disart Myoelectronic C	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6930	Below Elbow Switch Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6935	Below Elbow Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6940	Elbow Disarticulation Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6945	Elbow Disart Myoelectronic C	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6950	Above Elbow Switch Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6955	Above Elbow Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6960	Shldr Disartic Switch Contro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6965	Shldr Disartic Myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6970	Interscapular-Thor Switch Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L6975	Interscap-Thor Myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7008	Pediatric Electric Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7009	Adult Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7040	Prehensile Actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7045	Pediatric Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7170	Electronic Elbow Hosmer Swit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7180	Electronic Elbow Sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7181	Electronic Elbo Simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7185	Electron Elbow Adolescent Sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7186	Electron Elbow Child Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7190	Elbow Adolescent Myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7191	Elbow Child Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7364	Twelve Volt Battery Utah/Equ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7366	Battery Chrgr 12 Volt Utah/E	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–	
L7499	Upper Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
L8039	Breast Prosthesis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
L8048	Unspec Maxillofacial Prosth	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
L8499	Unlisted Misc Prosthetic Ser	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–	
L8604	Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	–	–	
L8605	Inj Bulking Agent Anal Canal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	–	–	
L8606	Synthetic Implnt Urinary 1Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	–	–	
L8608	Arg Ii Ext Com/Sup/Acc Misc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	–	–	
L8612	Aqueous Shunt Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–	
L8614	Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	–	–	
L8615	Coch Implant Headset Replace	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	–	–	

L8616	Coch Implant Microphone Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8617	Coch Implant Trans Coil Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8618	Coch Implant Tran Cable Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8623	Lith Ion Batt Cid Non-Earlvl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8628	Cid Ext Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8629	Cid Transmit Coil And Cable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.004	Cochlear Implant	_	_	_
L8690	Aud Osseo Dev Int/Ext Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_	_
L8691	Aoi Snd Proc Repl Excl Actua	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_	_
L8693	Aud Osseo Dev Abutment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_	_
L8699	Prosthetic Implant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
L8701	Ewh S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_	_
L8702	Ewhf S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_	_
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.013	Prolotherapy	_	_	_
P2031	Hair Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.014	Autism Spectrum Disorders (ASD)	_	_	_
P9020	Plaelet Rich Plasma Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_	_
P9099	Blood Component/Product Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
Q0507	Misc Sup/Acc Ext Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q0508	Misc Sup/Acc Imp Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q0509	Mis Sup/Ac Imp Vad Nopay Med	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q0510	Dispens Fee Immunosupressive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
Q0511	Sup Fee Antiem Antica Immuno	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
Q0512	Px Sup Fee Anti-Can Sub Pres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
Q2026	Radiesse Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
Q2028	Inj Sculptra 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.001	Cosmetic and Reconstructive Procedures	_	_	_
Q2039	Influenza Virus Vaccine Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q2041	Axicabtagene Ciloleucel Car+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.061	Oncology Medications	_	_	_
Q2042	Tisagenlecleucel Car-Pos T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.061	Oncology Medications	_	_	_
Q2050	Doxorubicin Inj 10Mg	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RX502.061	Oncology Medications	_	_	_
Q2052	Ivig Demo Services/Supplies	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
Q2053	Brexucabtagene Autoleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	RX502.061	Oncology Medications	_	_	_
Q2054	Lisocabtagene mara car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.061	Oncology Medications	_	_	_
Q2055	Idecabtagene Vicleucel Car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.061	Oncology Medications	_	_	_
Q2056	Ciltacabtagene car-pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.061	Oncology Medications	_	_	_
Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q4051	Splint Supplies Misc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q4082	Drug/Bio Noc Part B Drug Cap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_

Q4100	Skin Substitute Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4101	Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4102	Oasis Wound Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4103	Oasis Burn Matrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4104	Integra Bmwd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4105	Integra Drt Or Omnigraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4106	Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4107	Graftjacket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4108	Integra Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4110	Primatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4111	Gammagraft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4112	Cymetra Injectable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4113	Graftjacket Xpress	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4114	Integra Flowable Wound Matri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4115	Alloskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4118	Matristem Micromatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4121	Theraskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4122	Dermacell Awm Porous Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4125	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4126	Memoderm/Derma/Tranz/Integup	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4127	Talymed Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4128	Flexhd/Allopatchhd/Matrixhd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4130	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4132	Grafix core grafixpl core	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4133	Grafix stravix prime pl sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4134	Hmatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4135	Mediskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4136	Ezderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4137	Amnioexcel Biodexcel 1Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4138	Biodfence Dryflex 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4139	Amnio Or Biodmatrix Inj 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4140	Biodfence 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4141	Alloskin Ac 1 Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4142	Xcm Biologic Tiss Matrix 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4143	Repriza 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4145	Epifix Inj 1Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4146	Tensix 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4147	Architect Ecm Px Fx 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_

Q4148	Neox Neox Rt Or Clarix Cord	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4150	Allowrap Ds Or Dry 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4152	Dermapure 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4153	Dermavest Plurivest Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4154	Biovance 1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4155	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4156	Neox 100 Or Clarix 100	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4157	Revitalon 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4158	Kerecis Omega3 Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4159	Affinity1 Square Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4160	Nushield 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4161	Bio-Connekt Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4162	Wndex Flw Bioskn Flw 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4163	Woundex Bioskin Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4164	Helicoll Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4165	Keramatrix Kerasorb Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4166	Cytal Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4167	Truskin Per Sq Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4169	Artacent Wound Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4170	Cygnus Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4171	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4173	Palingen Or Palingen Xplus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4174	Palingen Or Promatrx	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4175	Miroderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4176	Neopatch Or Therion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4178	Floweramniopatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4179	Flowerderm Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4180	Revita Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4181	Amnio Wound Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4182	Transcyte Per Sq Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4183	Surgigraft 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4184	Cellesta Or Duo Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4185	Cellesta Flowab Amnion 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4187	Epicord 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4188	Amnioarmor 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4189	Artacent Ac 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_

Q4190	Artacent Ac 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4191	Restorigin 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4192	Restorigin 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4193	Coll-E-Derm 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4194	Novachor 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4195	Puraply 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4196	Puraply Am 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4197	Puraply Xt 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4198	Genesis Amnio Membrane 1Sqcm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4199	Cygnus Matrix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4200	Skin Te 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4201	Matrion 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4202	Keroxx (2.5G/Cc) 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4203	Derma-Gide 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4204	Xwrap 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4205	Membrane Graft Or Wrap Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4206	Fluid Flow Or Fluid Gf 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4208	Novafix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4209	Surgraft Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4210	Axolotl Graf Dualgraf Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4211	Amnion Bio Or Axobio Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4212	Allogen Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4213	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4214	Cellesta Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4215	Axolotl Ambient Cryo 0.1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4216	Artacent Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4217	Woundfix Biowound Plus Xplus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4218	Surgicord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4219	Surgigraft Dual Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4220	Bellacell Hd Surederm Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4221	Amniowrap2 Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4222	Progenamatrix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_	_
Q4224	Hhf10-P Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4225	Amniobind Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4227	Amniocore Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4229	Cogenex Amnio Memb Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4230	Cogenex Flow Amnion 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4231	Corplex P Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4232	Corplex Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_

Q4233	Surfactor /Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4234	Xcellerate Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4235	Amniorepair Or Altiply Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4236	Carepatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4237	Cryo-Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4238	Derm-maxx, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4239	Amnio-Maxx Or Lite Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4240	Corecyte Topical Only 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4241	Polycyte Topical Only 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4242	Amniocyte Plus Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4244	Procenta Per 200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4246	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4247	Amniotext Patch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4248	Dermacyte Amn Mem Allo Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4249	Amniply Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4250	Amnioamp-Mp Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4252	Vendaje per square centimet	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4253	Zenith amniotic membrane psc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4254	Novafix Dl Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4255	Reguard Topical Use Per Sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4256	Mlg Complet Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4257	Relese Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4258	Enverse Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4262	Dual layer impax, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4263	Surgraft tl, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q4264	Cocoon membrane, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_	_
Q5009	Hospice Care Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
Q5103	Injection Inflectra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.051 RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	_	_	_
Q5104	Injection Renflexis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.051 RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	_	_	_
Q5106	Inj Retacrit Non-Esrd Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	_	_	_
Q5109	Injection Ixifi 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.051	Infliximab and Associated Biosimilars	_	_	_
Q5115	Inj Truxima 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	_	_	_
Q5124	Inj. Byooviz 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	_	_	_
S0013	Esketamine Nasal Spray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.105	Esketamine Nasal Spray	_	_	_
S0117	Tretinoin Topical 5 G	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

S0142	Colistimethate Inh Sol Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S0157	Becaplermin Gel 1% 0.5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_	_
S0197	Prenatal Vitamins 30 Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S0310	Hospitalist Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S0320	Rn Telephone Calls To Dmp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S0590	Misc Integral Lens Serv	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S0622	Phys Exam For College	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S0800	Laser In Situ Keratomileusis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.001	Refractive and Therapeutic Keratoplasty	_	_	_
S0810	Photorefractive Keratectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S1001	Deluxe Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S1002	Custom Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S1091	Stent Non-Coronary Propel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR706.001	Nasal and Sinus Surgery	_	_	_
S2083	Adjustment Gastric Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR716.003	Bariatric Surgery	_	_	_
S2112	Knee Arthroscp Harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	_	_	_
S2117	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	_	_	_
S2118	Total Hip Resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR705.019	Hip Resurfacing (HR)	_	_	_
S2120	Low Density Lipoprotein(Ldl)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement	THE802.003	Lipid Apheresis	_	_	_
S2140	Cord Blood Harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_
S2142	Cord Blood-Derived Stem-Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_

S2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	_	_	_
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR707.016	Varicose Vein Management	_	_	_
S2230	Implant Semi-Imp Hear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	_	_	_
S2235	Implant Auditory Brain Imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.009	Auditory Brainstem Implant	_	_	_
S2300	Arthroscopy Shoulder Surgi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.041	Thermal Capsulorrhaphy as a Treatment of Joint Instability	_	_	_
S2409	Fetal Surg Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S2411	Fetoscop laser ther TTTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	_	_	_
S2900	Surgical Techniques Requiring Use Of Robotic Surgical System (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR701.014	Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery	_	_	_
S3600	Stat Lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S3601	Stat Lab Home/Nf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S3650	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	_	_	_
S3652	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	_	_	_
S3900	Surface Emg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	_	_	_
S4015	Complete Ivf Nos Case Rate	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S4023	Incompl Donor Egg Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4025	Donor Serv Ivf Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4026	Procure Donor Sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4027	Store Prev Froz Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4030	Sperm Procure Init Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4031	Sperm Procure Subs Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4040	Monit Store Cryo Embryo 30 D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_	_
S4990	Nicotine Patch Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S4991	Nicotine Patch Nonlegend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S4995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5035	Hit Routine Device Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5036	Hit Device Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5100	Adult Daycare Services 15Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5101	Adult Day Care Per Half Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5102	Adult Day Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5105	Centerbased Day Care Perdiem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5108	Homecare Train Pt 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5109	Homecare Train Pt Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5110	Family Homecare Training 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5111	Family Homecare Train/Sessio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5115	Nonfamily Homecare Train/15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5116	Nonfamily Hc Train/Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5120	Chore Services Per 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5121	Chore Services Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

S5125	Attendant Care Service /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5126	Attendant Care Service /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5130	Homaker Service Nos Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
S5131	Homemaker Service Nos /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
S5135	Adult Companioncare Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5136	Adult Companioncare Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5140	Adult Foster Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5141	Adult Foster Care Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5145	Child Fostercare Th Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5146	Ther Fostercare Child /Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5150	Unskilled Respite Care /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5151	Unskilled Respitecare /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5160	Emer Response Sys Instal&Tst	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5161	Emer Rspns Sys Serv Permonth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5162	Emer Rspns System Purchase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5165	Home Modifications Per Serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5170	Homedelivered Prepared Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5175	Laundry Serv Ext Prof /Order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5181	Hh Respiratory Thrpy Nos/Day	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S5185	Med Reminder Serv Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
S5497	Hit Cath Care Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	_	_	_
S8130	Interferential Current Stimulator 2 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	_	_	_
S8131	Interferential Current Stimulator 4 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	_	_	_
S8189	Trach Supply Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S8270	Enuresis Alarm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S8301	Infect Control Supplies Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S8460	Camisole Post-Mast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S8930	Auricular Electrostimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	_	_	_
S8940	Hippotherapy Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.022	Hippotherapy	_	_	_
S8948	Low-Level Laser Trmt 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	THE801.028 SUR702.005 MED201.045 MED205.022	Acne Management Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence Low-Level and High-Power Laser Therapy Treatment of Tinnitus	_	_	_
S8990	Pt Or Manip For Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9001	Home Uterine Monitor With Or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.017	Home Uterine Activity Monitoring	_	_	_
S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.014	Sensory Stimulation for Coma Patients	_	_	_
S9090	Vertebral Axial Decompressio	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.021	Non-Surgical Spinal Decompression Traction Devices	_	_	_
S9117	Back School Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.024	Back School	_	_	_
S9125	Respite Care In The Home P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9335	Ht Hemodialysis Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	_	_
S9379	Hit Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S9381	Hit High Risk/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9436	Lamaze Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9437	Childbirth Refresher Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9439	Vbac Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9442	Birthing Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9444	Parenting Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9445	Pt Education Noc Individ	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S9446	Pt Education Noc Group	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	_	_	_	_	_
S9447	Infant Safety Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9449	Weight Mgmt Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

S9451	Exercise Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9454	Stress Mgmt Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9472	Cardiac Rehabilitation Progr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	THE803.023	Cardiac Rehabilitation (CR)	_	_	_
S9482	Family Stabilization 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9542	Ht Inj Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S9558	Ht Inj Growth Horm Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX501.040	Human Growth Hormone (GH)	_	_	_
S9562	Ht Inj Palivizumab Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	_	_	_
S9810	Ht Pharm Per Hour	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
S9900	Christian Sci Pract Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9970	Health Club Membership Yr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9975	Transplant Related Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9976	Lodging Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	SUR703.001	_	_	_	_
S9977	Meals Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	SUR703.001	_	_	_	_
S9981	Med Record Copy Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9982	Med Record Copy Per Page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9986	Not Medically Necessary Svc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9988	Serv Part Of Phase I Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9990	Services Provided As Part Of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9991	Services Provided As Part Of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9992	Transportation Costs To And	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9994	Lodging Costs (E.G. Hotel Ch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9996	Meals For Clinical Trial Par	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
S9999	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
T1014	Telehealth Transmit Per Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
T1505	Elec Med Comp Dev Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T1999	Noc Retail Items Andsupplies	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2012	Habil Ed Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2013	Habil Ed Waiver Per Hour	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2014	Habil Prevoc Waiver Per D	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2015	Habil Prevoc Waiver Per Hr	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2016	Habil Res Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2017	Habil Res Waiver 15 Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2018	Habil Sup Empl Waiver/Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2019	Habil Sup Empl Waiver 15Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2020	Day Habil Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2021	Day Habil Waiver Per 15 Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2024	Serv Asmnt/Care Plan Waiver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2025	Waiver Service Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2026	Special Childcare Waiver/D	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2027	Spec Childcare Waiver 15 Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2028	Special Supply Nos Waiver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2029	Special Med Equip Noswaiver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2030	Assist Living Waiver/Month	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2031	Assist Living Waiver/Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2032	Res Care Nos Waiver/Month	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2033	Res Nos Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2034	Crisis Interven Waiver/Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2035	Utility Services Waiver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2036	Camp Overnite Waiver/Session	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2037	Camp Day Waiver/Session	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2038	Comm Trans Waiver/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2039	Vehicle Mod Waiver/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2040	Financial Mgt Waiver/15Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2041	Support Broker Waiver/15 Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
T2101	Breast Milk Proc/Store/Dist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
T5999	Supply Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V2025	Eyeglasses Delux Frames	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_

V2199	Lens Single Vision Not Oth C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V2599	Contact Lens/Es Other Type	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V2629	Prosthetic Eye Other Type	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
V2744	Tint Photochromatic Lens/Es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_	_
V2787	Astigmatism-Correct Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_	_
V2788	Presbyopia-Correct Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_	_
V2799	Misc Vision Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	OTH903.012 DME104.003	_	_	_	_
V5090	Hearing Aid Dispensing Fee	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5095	Implant Mid Ear Hearing Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	_	_	_
V5267	Hearing Aid Sup/Access/Dev	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5274	Ald Unspecified	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5287	Ald Fm/Dm Receiver Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5298	Hearing Aid Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5299	Hearing Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_	_
V5362	Speech Screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.014	Autism Spectrum Disorders (ASD)	_	_	_
V5363	Language Screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review	PSY301.014	Autism Spectrum Disorders (ASD)	_	_	_