

Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered 2023 Commercial Benefit Procedure Code List Posted April 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.
iviedical Policy Criteria (MP Criteria)	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).
Unlisted or Undefined	Procedures/services not specifically defined or classified, 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.

	Code Boomistics	Code Course Provided to	Effective	Ending	No. de de
ode	Code Description	Code Group & Description	Date	Date	Updates
40	ANESTH SPINE MANIPULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
97	ANESTH SURGERY FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
57	Weight Loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
00	REMOVAL OF SKIN TAGS <w 15<="" td=""><td>Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.</td><td>_</td><td>_</td><td>_</td></w>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
01	REMOVE SKIN TAGS ADD-ON	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
20	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.	_	_	_
21	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.	_	_	_
922	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.	_	_	_
50	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.	_	_	_
951	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.	_	_	_
952	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.		_	
54	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.	_		_
60	INSERT TISSUE EXPANDER(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
70	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.			_
80	IMPLANT HORMONE PELLET(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
71	Skin Sub Graft Trnk/Arm/Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/20
172	Skin Sub Graft T/A/L Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/20
73	Skin Sub Gritt T/Arm/Lg Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/20
274	Skn Sub Grft T/A/L Child Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/20
275	Skin Sub Graft Face/Nk/Hf/G	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/20
276	Skin Sub Graft F/N/Hf/G Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/20
277	Skn Sub Grift F/N/Hf/G Child	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/20
778		WP Criteria: Procedure/service reviewed against Medical Policy Circleria. Submit for Recommended Clinical Review (Predestimation) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Circleria. Submit for Recommended Clinical Review (Predestimation) to avoid post-service review.		-	
758	Skn Sub Grft F/N/Hf/G Ch Add		4/1/2023	_	Add effective 04/01/20
769	FREE FASCIAL FLAP MICROVASC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
	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.	_	_	_
771	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.	_	_	-
772	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.	-	-	-
775	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.	_	-	_
776	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.	_	_	_
780	DERMABRASION TOTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
781	DERMABRASION SEGMENTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
782	DERMABRASION OTHER THAN FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
783	DERMABRASION SUPRFL ANY SITE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
786	ABRASION LESION SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
787	ABRASION LESIONS ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
788	CHEMICAL PEEL FACE EPIDERM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
789	CHEMICAL PEEL FACE DERMAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
792	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
793	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
320	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
821	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
822	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
823	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
B24	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.	-	_	-
25	REMOVAL OF NECK WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
326	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.	-	_	-
28	REMOVAL OF FACE WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
29	REMOVAL OF SKIN WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	EXC SKIN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
B30					
330 332	EXCISE EXCESSIVE SKIN THIGH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	

15835	EVOICE EVOESSIVE OVIN DUITTON	MD Criteria: Procedure/conice reviewed against Modical Policy Criteria Culturi for December and Clinical Policy Criteria			
	EXCISE EXCESSIVE SKIN BUTTCK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
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.			
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.			
15838	EXCISE EXCESS SKIN FAT PAD	WP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. WP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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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.	_	_	_
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.			
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.	_		-
		MP Criteria: Procedure/service reviewed against medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
15877	SUCTION LIPECTOMY TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.	_	_	_
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.			_
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15999	UNLISTED PX EXC PRESSURE ULC	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
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.			
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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.	_	_	_
17340	CRYOTHERAPY OF SKIN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
17360	SKIN PEEL THERAPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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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.	_	_	-
17999	UNLISTD PX SKN MUC MEMB SUBQ	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
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.	_	_	-
19303	MAST SIMPLE COMPLETE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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			
15510	JOSEPHSION OF BREAST	required per contract agreement.	-	-	-
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.			-
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.	_	_	_
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.			
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.	-	-	-
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.			
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.			
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19350	BREAST RECONSTRUCTION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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.	_	_	
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.	_		
19370	REVI PERI-IMPLT CAPSULE BRST				-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
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.	_	_	
19499	UNLISTED PROCEDURE BREAST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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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.			_
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).			
	. ,		-	_	-
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.	-	-	_
20985	CPTR-ASST DIR MS PX	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		_
20999	UNLISTED PX MUSCSKEL GENERAL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
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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.	_		_
21089	UNLISTED MAXLECL PROSTH PX	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_		
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21121	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
21122	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
21123	RECONSTRUCTION OF CHIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			-
21125	Augmentation Lower Jaw Bone	Wir Citedia. Flocustic James to Everwed against wedical Policy Citedia. Journal of Recommended Citidia Review (Fredetermination) to avoid post-service review. First Additionation may be required per contract agreement.	_	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
21127	Augmentation Lower Jaw Bone	required per contract agreement.	-	-	-
24445		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
21145	Lefort I-1 Piece W/ Graft	required per contract agreement.	-	-	-
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			
21146	Lefort I-2 Piece W/ Graft	required per contract agreement.			_
			-	-	
21147	Lefort L2 /s Diago 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	=	_	
21147	Lefort I-3/> Piece W/ Graft	required per contract agreement.	-	-	-
		required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	-	-
21147 21150	Lefort I-3/> Piece W/ Graft Lefort Ii Anterior Intrusion	required per contract agreement. 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.	- - -	- -	-
	Lefort li Anterior Intrusion	required per contract agreement. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	-	-
21150		required per contract agreement. 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. 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.	- - -	- - -	- -
21150	Lefort li Anterior Intrusion	required per contract agreement. 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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	- - -	-
21150 21151 21154	Lefort Ii M/Bone Grafts Lefort Ii W/O Lefort I	required per contract agreement. 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. 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. 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.	- - -	- - - -	- - -
21150 21151	Lefort Ii Anterior Intrusion Lefort Ii W/Bone Grafts	required per contract agreement. 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. 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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	- - - -	- - - -	-
21150 21151 21154 21155	Lefort Ii M/Bone Grafts Lefort Ii W/O Lefort I Lefort Ii W/ Lefort I	required per contract agreement. 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. 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. 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. 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.	- - - -	- - - -	- - - -
21150 21151 21154	Lefort Ii M/Bone Grafts Lefort Ii W/O Lefort I	required per contract agreement. 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. 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. 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. 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. 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.	-	- - - -	-
21150 21151 21154 21155 21159	Lefort Ii Anterior Intrusion Lefort Ii W/Bone Grafts Lefort Iii W/O Lefort I Lefort Iii W/ Lefort I Lefort Iii W/Fhdw/O Lefort I	required per contract agreement. 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. 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. 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. 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. 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. 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.	-	- - - -	- - - -
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27280					
27200	ARTHR SI JT OPN B1GRF INSTRM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27299	UNLISTED PX PELVIS/HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
27599	UNLISTED PX FEMUR/KNEE	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
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.	_	_	-
27899	UNLISTED PX LEG/ANKLE	Unlisted: Procedure/service not specifically defined or classified, maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
28899	UNLISTED PX FOOT/TOES	Unlisted: Procedure/service not specifically defined or classified, maybe 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					=
	UNLISTED PX CASTING/STRPG	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	-
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.	_	_	_
29915	HIP ARTHRO ACETABULOPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.	_	_	_
29999	UNLISTED PX ARTHROSCOPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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30468	RPR NSL VLV COLLAPSE W/IMPLT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
30469	RPR NSL VLV COLLAPSE W/RMDLG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
30999	UNLISTED PROCEDURE NOSE	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
31299	UNLISTED PX ACCESSORY SINUS	Unlisted Procedure; May require Prior Authorization per contract agreement.			
31599					-
	UNLISTED PROCEDURE LARYNX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
31899	UNLISTED PX TRACHEA BRONCHI	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
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.	_	_	_
32999	UNLISTED PX LUNGS & PLEURA	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	-	-	-
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.	_	_	-
33268	EXCL LAA OPN OTH PX ANY METH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.	_	_	_
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.			
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.			-
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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.	_	_	-
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.	_	_	_
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.	_	_	_
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.			
33999	LINUSTED PX CARDIAC SURGERY				-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
36299	UNLISTED PX VASCULAR NJX	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
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.	_	_	_
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.			
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.			-
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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.			-
36473	ENDOVENOUS MCHNCHEM 1ST VEIN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
36474	ENDOVENOUS MCHNCHEM ADD-ON	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
36475	ENDOVENOUS RF 1ST VEIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.			-
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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.			-
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.	_	_	_
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.	_	_	_
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.		_	_
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36516	Apheresis Immunoads SIctv		- -	- -	-
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36516	Apheresis Immunoads SIctv	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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	- 1/1/2023 1/1/2023	-	
36516 36836	Apheresis Immunoads SIctv PRQ AV FSTL CRTJ UXTR 1 ACS PRQ AV FSTL CRT UXTR SEP ACS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be resulted per contract agreement. EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		- - -	
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38243					
	TRANSPLI HEMATOPOIETIC BOOST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
38589	UNLISTED LAPS PX LYMPHTC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
38999	UNLISTD PX HEMIC/LYMPHTC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
39499	UNLISTED PX MEDIASTINUM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
39599	UNLISTED PX DIAPHRAGM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
40799	UNLISTED PROCEDURE LIPS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
40899	UNLISTED PX VESTIBULE MOUTH	Unlisted: Procedure/service not specifically defined or classified, maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
41599	UNLISTED PX TONGUE FLR MOUTH	Unlisted: Procedure/service not specifically defined or classified, maybe 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 41830	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.			_
41899	Repair Tooth Socket	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_		_
42299	UNLISTED PX DENTALVER STRUX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
42699	UNLISTED PX PALATE UVULA UNLISTED PX SALIVRY GLND/DUX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
42999	UNLISTED PX SALIVAT GLIND/DOX UNLISTED PX PHRNX ADND/TNSL	Unlisted: Procedure/service not specifically defined or classified, maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).	-		
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.	_		_
43252	EGD OPTICAL ENDOMICROSCOPY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
43284	LAPS ESOPHGL SPHNCTR AGMNTJ	MP Criteria: Procedure/service reviewed against. Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
43289	UNLISTED LAPS PX ESOPH	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_		-
43290	EGD FLX TRNSORL DPLMNT BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023		Add effective 01/01/2023
43291	EGD FLX TRNSORL BY LWINT BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023		Add effective 01/01/2023
43499	UNLISTED PROCEDURE ESOPHAGUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
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.			
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.	_	_	_
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.	_	_	
43659	UNLISTED LAPS PX STOMACH	Unlisted: Procedure/service not specifical ugly defined or classified, maybe 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.			
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.			_
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.	_	_	_
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.	_	_	_
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.	_	_	_
43775	LAP SLEEVE GASTRECTOMY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
43842	V-BAND GASTROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
43845	GASTROPLASTY DUODENAL SWITCH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
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54699	UNLISTED LAPS PX TESTIS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
55559	UNLSTD LAPS PX SPRMATIC CORD	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_		-
55899	UNLISTED PX MALE GENITAL SYS	MP Criteria. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	-
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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.	_	-	-
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.	_	_	_
56805	REPAIR CLITORIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
56810	REPAIR OF PERINEUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
57291	CONSTRUCTION OF VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
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.	-	_	-
57335	REPAIR VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
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.	_	_	_
58578	UNLISTED LAPS PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
58579	UNLISTED HYSTSC PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
58679	UNLISTED LAPS PX OVIDCT OVRY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
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58999	UNLISTED PX FML GENITAL SYS	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	-	_	_
59897	UNLISTED FETAL INVAS PX W/US	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
59898	UNLSTD LAPS PX MAT CARE&DLVR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
59899	UNLISTED PX MAT CARE&DLVR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
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60659	UNLISTED LAPS PX ENDOC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
60699	UNLISTED PX ENDOCRINE SYSTEM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
61630	INTRACRANIAL ANGIOPLASTY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
61635	INTRACRAN ANGIOPLSTY W/STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
61650	Evasc Pring Admn Rx Agnt 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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62263	EPIDURAL LYSIS MULT SESSIONS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
62264	EPIDURAL LYSIS ON SINGLE DAY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
62287	DCMPRN PX PERQ 1/MLT LUMBAR	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
64503	ODNI MIDITI LIDGI SI NISTANA DIVING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
64582	OPN MPLTJ HPGLSL NSTM ARY PG	required per contract agreement.	-	-	-
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
64629	TRML DSTRJ IOS BVN EA ADDL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
64640	INJECTION TREATMENT OF NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
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64999	UNLISTED PX NERVOUS SYSTEM	Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
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.	_	_	_
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.			
66174	TRLUML DIL AQ O/F CAN W/O ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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66175	TRLUML DIL AQ O/F CAN W/ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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.		_	_
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.	_	_	_
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.			
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.			-
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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.			-
66999	UNLISTED PX ANT SEGMENT EYE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_
67299	UNLISTED PX POSTERIOR SEGMNT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67399	UNLISTED PX EXTRAOCULAR MUSC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
67599	UNLISTED PROCEDURE ORBIT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
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67900	REPAIR BROW DEFECT	required per contract agreement.	-	-	-
67901	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
67902	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
67903	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		-
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67904	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		
67906			_	_	_
67908	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_ _ _		
6/908	REPAIR EYELID DEFECT REPAIR EYELID DEFECT				_
67999		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- -	- - -
67999	REPAIR EYELID DEFECT UNLISTED PROCEDURE EYELIDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review.	-	- - -	- - -
67999 68399	REPAIR EYELID DEFECT UNLISTED PROCEDURE EYELIDS UNLISTED PX CONJUNCTIVA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	- - - -	-
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79999	RP THERAPY UNLISTED PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
80299	QUANTITATIVE ASSAY DRUG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
81099	UNLISTED URINALYSIS PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
81479	UNLISTED MOLECULAR PATHOLOGY	Unlisted Procedure: May require Prior Authorization per contract agreement			_
81599	UNLISTED MAAA				-
82523	COLLAGEN CROSSLINKS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		-
83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
83695	ASSAY OF LIPOPROTEIN(A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		_
83698	ASSAY LIPOPROTEIN PLA2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83701	LIPOPROTEIN BLD HR FRACTION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83704	LIPOPROTEIN BLD QUAN PART	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83722	LIPOPRTN DIR MEAS SD LDL CHL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83937	ASSAY OF OSTEOCALCIN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
83987	EXHALED BREATH CONDENSATE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
84112	EVAL AMNIOTIC FLUID PROTEIN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		_
84431	THROMBOXANE URINE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
84999	UNLISTED CHEMISTRY PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
85999	UNLISTED HEMATOLOGY&COAGJ PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
86001					_
86343	ALLERGEN SPECIFIC IGG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
	LEUKOCYTE HISTAMINE RELEASE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
86352	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.	_		_
86353	LYMPHOCYTE TRANSFORMATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
86486	SKIN TEST UNLISTED ANTIGN EA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
86849	IMMUNOLOGY PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
86999	UNLISTED TRANSFUSION MED PX	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	
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.			_
87507	IADNA-DNA/RNA PROBE TQ 12-25	WP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid poss-service review. WP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid poss-service review.	_	_	-
87797	DETECT AGENT NOS DNA DIR	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, maybe subject to contract/clinical review.			_
87798	DETECT AGENT NOS DNA DIR		-	-	-
		Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		-
87799	DETECT AGENT NOS DNA QUANT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
87899	AGENT NOS ASSAY W/OPTIC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
87999	UNLISTED MICROBIOLOGY PX	Unlisted: Procedure/service not specifically defined or classified, maybe 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					-
88036	AUTOPSY (NECROPSY) COMPLETE LIMITED AUTOPSY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_	_
88037		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
	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.		_	_
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88040	FORENSIC AUTOPSY (NECROPSY)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_ _ _	-
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HAST W/OXYGEN TITRATE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
UNLISTED PULMONARY SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
EYE ALLERGY TESTS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
NOSE ALLERGY TEST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
UNLISTED ALL/IMMLG SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	_
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.	_	_	_
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.		-	_
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.		-	_
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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.		_	
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.		_	_
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.		_	_
ACTIGRAPHY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
MOTOR &/ SENS NRVE CNDJ TEST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
QUAN PUPLMTRY PHY/QHP UNI/BI	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
Eeg Monitoring/Giving Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
MEG SPONTANEOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
MEG EVOKED SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
MEG EVOKED EACH ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
MOTION ANALYSIS VIDEO/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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MOTION TEST W/FT PRESS MEAS DYNAMIC SURFACE EMG PYNAMIC FINE WIRE EMG PHYS REVIEW OF MOTION TESTS UNL THER/PROP/DIAG INJ/INF UNUSTED CHEMOTHERAPY PX PHOTOCHEMOTHERAPY WITH UV-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - - -	-
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		UNLISTED SPEC DERM SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
Column C		UNLISTED MODALITY	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
1.	97139	UNLISTED THERAPEUTIC PX	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	-	_
10. March 16. March	97169	Athletic Trn Eval Low Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
March Marc	97170	Athletic Trn Eval Mod Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
Management Man						
						
Section				_	_	_
	97533	Sensory Integration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
10.000 10.00	97537	Community/Work Reintegration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	=
1000 1000	97610	LOW FREQUENCY NON-THERMAL US	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Texas						
March Marc						-
March Marc			Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			_
1985 1985 1985 1986	99026	IN-HOSPITAL ON CALL SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
1806 1806	99027	OUT-OF-HOSP ON CALL SERVICE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
1.00 1.00	99050	MEDICAL SERVICES AFTER HRS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
1982		MED SERVICE OUT OF OFFICE				-
1879						-
Series Se				_	_	_
March Marc	99070	SPECIAL SUPPLIES PHYS/QHP	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	_	_	_
Control Cont	99071	PATIENT EDUCATION MATERIALS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
1.00	99075	MEDICAL TESTIMONY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
10.000 10.00	99078		Unlisted: Procedure/service ant specifically defined or classified maybe subject to contract/clinical review	_	_	
March Marc				_	_	_
March Control Contro	99082	UNUSUAL PHYSICIAN TRAVEL		_	_	=
Manipulation Mani	99183	Hyperbaric Oxygen Therapy				
MINISTERS MINI						
1985 1985			Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
Sept		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, maybe 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.			
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1985 Septiminaries				-		-
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1985 Septim Microsoft 1975			Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_		_
Sept	99450	BASIC LIFE DISABILITY EXAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
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No. 1960 May 1975 2016 See 201	99455	WORK RELATED DISABILITY EXAM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
An	99456	DISABILITY EXAMINATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
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Column C		UNLISTED E&M SERVICE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
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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 Ritd Do Pni 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 Ritd 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 Ritd 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.			
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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.			
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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.			
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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					
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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.			
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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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0202T	POST VERT ARTHRPLST 1 LUMBAR	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
0207T	CLEAR EYELID GLAND W/HEAT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0219T	PLMT POST FACET IMPLT CERV	EU: Procedure/service not reimbursed by the Plan. Not subject to preservice review. Check EUI policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
			-	-	-
0220T	PLMT POST FACET IMPLT THOR	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0221T	PLMT POST FACET IMPLT LUMB	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		_
0222T	PLMT POST FACET IMPLT ADDL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0232T	NJX PLATELET PLASMA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0253T	INSERT AQUEOUS DRAIN DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0253T 0263T					-
	IM B1 MRW CEL THER CMPL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
0264T	IM B1 MRW CEL THER XCL HRVST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
0265T	IM B1 MRW CEL THER HRVST ONL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0266T	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.			
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.	_		
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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.	_	_	-
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.			
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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.	_	_	-
0270T 0271T	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
0271T	REV/REMVL CRTD SNS DEV LEAD 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.	-		
0271T 0272T	REV/REMVL CRTD SNS DEV LEAD REV/REMVL CRTD SNS DEV GEN INTERROGATE CRTD SNS DEV	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
0271T 0272T 0273T	REV/REMVL CRTD SNS DEV LEAD REV/REMVL CRTD SNS DEV GEN INTERROGATE CRTD SNS DEV 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	
0271T 0272T 0273T 0274T	REV/REMVL CRTD SNS DEV LEAD REV/REMVL CRTD SNS DEV GEN INTERROGATE CRTD SNS DEV INTERROGATE CRTD SNS W/PGRMG PERQ LAMOT/LAM CRV/THRC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	- - - -
0271T 0272T 0273T 0274T 0275T	REV/REMVL CRTD SNS DEV LEAD REV/REMVL CRTD SNS DEV GEN INTERROGATE CRTD SNS DEV 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	- - - - -
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April 2023

	TMVI PERCUTANEOUS APPROACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0484T	TMVI TRANSTHORACIC EXPOSURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	OCT MID EAR I&R UNILATERAL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
	OCT MID EAR I&R BILATERAL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0499T	CYSTO F/URTL STRIX/STENOSIS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0509T	PATTERN ERG W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0511T	RMVL&RINSJ SINUS TARSI IMPLT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0512T	ESW INTEG WND HLG 1ST WND	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0513T	ESW INTEG WND HLG EA ADDL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0524T	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.	_	_	-
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
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0534T	CONT REC MVMT DO SETUP&TRAIN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-		_
0535T	CONT REC MVMT DO REPRT CNFIG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		-
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	-
0563T	EVAC MEIBOMIAN GLND HEAT BI	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0565T	AUTOL CELL IMPLT ADPS HRVG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0566T	AUTOL CELL IMPLT ADPS NJX	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	_
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.	_	_	_
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.			
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.			
0602T	TRANSDERMAL GFR MEASUREMENTS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		-
	TRANSDERMAL GFR MEASUREMENTS TRANSDERMAL GFR MONITORING	EIU. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
0615T	EYE MVMT ALYS W/O CALBRI I&R		-		-
	EVE MVMT ALYS W/O CALBRI I&R EVASC VEN ARTIZ TIBI /PRNI VN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	EVASC VEN ARTLZ TIBL/PRNL VN TRABECLII OSTOMY INTERNO LASER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	TRABECULOSTOMY INT LSR W/SCP	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	AUTO QUANTIFICATION C PLAQUE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
	AUTO QUAN C PLAQ DATA PREP	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0625T	AUTO QUAN C PLAQ CPTR ALYS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0626T	AUTO QUAN C PLAQ I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
0627T	PERQ NJX ALGC FLUOR LMBR 1ST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0628T	PERQ NJX ALGC FLUOR LMBR EA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0629T	PERQ NJX ALGC CT LMBR 1ST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0630T	PERO NJX ALGC CT LMBR EA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
0631T	TC VIS LIT HYPERSPECTRAL IMG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
0632T	PERO TCAT US ABLTJ NRV P-ART	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU plugicy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
0639T	WRLS SKN SNR ANISOTROPY MEAS	EIU. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
0640T			-	-	-
	NCNTC NR IFR SPCTRSC WND	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
0641T	NCNTC NR IFR SPCTRSC WND IMG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
0651T	MAG CTRLD CAPSULE ENDOSCOPY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
0656T	VRT BDY TETHERING ANT <7 SEG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
	VRT BDY TETHERING ANT 8+ SEG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0658T	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.	_	_	-
	DON HYSTERECTOMY OPEN CDVR		_	_	_
	DON HYSTERECTOMY OPEN CDVR DON HYSTERECTOMY OPEN LIV	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		-
	DON HYSTERECTOMY LAPS LIV	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		-
0667T	DON HYSTERECTOMY RCP UTER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0668T	BKBENCH PREP DON UTER ALGRFT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0669T	BKBENCH RCNSTJ DON UTER VEN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0670T	BKBENCH RCNSTJ DON UTER ARTL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0672T	NDOVAG CRYG RF REMDL TISS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
	ARTHRD SI JT PRQ IARTIC IMPL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023		Add effective 01/01/2023
	TC AURICULR NEUROSTIMULATION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023		Add effective 01/01/2023
	Motor-cognitive, semi-immersive virtual	10. Procedur/service not reimbursed by the Plan. Not subject to pre-service review. Cleak to point, which is one of our Clinical Payment and Coding Policy (PCP).	7/1/2023	_	Add effective 07/01/2023
	reality–facilitated gait training, each 15 minutes (List				
0793T	separately in addition to code for primary procedure) Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	-	Add effective 07/01/2023
	catheterization, pulmonary artery angiography, and all imaging guidance Transcatheter insertion of permanent dual-chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
	leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right wantifular accemaker components)				
	ventricular pacemaker components)				
0796Т	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
1797T	seatami? Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	(when part of a dual-chamber leadless pacemaker				

0799T	Transcatheter removal of permanent dual-chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
	leadless pacemaker, including imaging guidance (e.g.,				
	fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when				
	performed; right atrial pacemaker component				
0800T	Transcatheter removal of permanent dual-chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023		Add effective 07/01/2023
	leadless pacemaker, including imaging guidance (e.g.,		.,.,	_	
	fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when				
	performed; right ventricular pacemaker component				
	(when part of a dual-chamber leadless pacemaker				
0801T	Transcatheter removal and replacement of permanent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
	dual-chamber leadless pacemaker, including				
	imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral				
	venography) and device evaluation (e.g., interrogation				
	or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker				
	components)				
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	imaging guidance (e.g., fluoroscopy, venous ultrasound,				
	right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation				
	or programming), when performed; right atrial				
0803T	nacemaker component Transcatheter removal and replacement of permanent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023		Add effective 07/01/2023
00031	dual-chamber leadless pacemaker, including	wir Citeria. Procedure/service reviewed against wedicar Policy Citeria. Sudmit für Accommended Cinicar Nevew (Predeterninaturi) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	imaging guidance (e.g., fluoroscopy, venous ultrasound,				
	right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation				
	or programming), when performed; right ventricular				
	pacemaker component (when part of a dual-chamber				
	leadless pacemaker system)				
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	function of device and to select optimal permanent				
	programmed values, with analysis, review, and report,				
	by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac				
08057	chambers		7/4/		Add officials and first
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	percutaneous femoral vein approach				
0806T	Transcatheter superior and inferior year cava proethotic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023		Add effective 07/01/2023
20001	valve implantation (i.e., caval valve implantation [CAVI]);		,,2,2023	-	a circuite 07/01/2023
0807T	open femoral vein approach Pulmonary tissue ventilation analysis using software-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023		Add effective 07/01/2023
06071	based processing of data from separately captured	ELO. Procedure/service not reminurised by the Plant. Not subject to pre-service review. Check Elo poncy, which is one or our climical Payment and Coding Poncy (CPCP).	7/1/2023	-	Add effective 07/01/2025
	cinefluorograph images; in combination with previously				
	acquired computed tomography (CT) images, including data preparation and transmission, quantification of				
	pulmonary tissue ventilation, data review, interpretation				
0808T	and report Pulmonary tissue ventilation analysis using software-	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023		Add effective 07/01/2023
	based processing of data from separately captured	, and the state of	., _, _,	-	2 222/2 07/02/2023
	cinefluorograph images; in combination with computed				
	tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data				
	preparation and transmission, quantification of				
	pulmonary tissue ventilation, data review, interpretation				
	and report				
0810T	and report Subretinal injection of a pharmacologic agent, including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effective 07/01/2023
0810T 213AA	and report Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	and report Subretinal injection of a pharmacologic agent, including witrectomy and 1 or more retinotomies Proc/Treat/Equip/ins/Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA	and report Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA	and renort Subretinal injection of a pharmacologic agent, including wtrectomy and 1 or more retinotomies Proc/Treat/Equip/Ins/Non-Covered OTC Drugs Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA 213CA	and renort Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies Proc/Treat/Equip/ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023 - - - -	-	Add effective 07/01/2023
213AA 213BA 213CA 213EA	and renort Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies Prot/Treat/Equip/ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assit Disabled/Misc Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA 213CA 213EA 213FA	and renort Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies Proc/Treat/Equip/ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assit Disabled/Misc Non-Covered Corr Eye Surgery Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA 213CA 213EA 213EA 213FA 213GA 213HA 213JA	and renort Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies ProofTreat/Equip/Ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assit Disabled/Misc Non-Covered Corr Eye Surgery Non-Covered Premiums Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA 213CA 213EA 213FA 213FA 213GA 213HA 213JA	and renort Subretinal injection of a pharmacologic agent, including virectomy and 1 or more retinotomies Proc/Treat/Equip/ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assis Disabled/Miss Non-Covered Corr Eye Surgery Non-Covered Premiums Non-Covered Copays Non-Covered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
213AA 213BA 213CA 213EA 213FA 213FA 213GA 213HA 213JA 213KA 213LA	and renort Subretinal injection of a pharmacologic agent, including virectomy and 1 or more retinotomies Proc/Treat/Equip/Ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assit Disabled/Misc Non-Covered Corr Eye Surgery Non-Covered Premiums Non-Covered Premiums Non-Covered Limited Purpose HCA Non-Covered Limited Purpose HCA Non-Covered Long Term Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2023	-	Add effective 07/01/2023
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213AA 213BA 213BA 213BA 213GA 213FA	and tenor Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies Proc/Treat/Equip/Ins/Non-Covered OTC Drugs Non-Covered Vision/Hear/Dental Non-Covered Assit Disabled/Misc Non-Covered Corr Eye Surgery Non-Covered Premiums Non-Covered Premiums Non-Covered Premiums Non-Covered Premiums Non-Covered Preventative Care Non-Covered Preventative Care Non-Covered India Company Non-Covered Preventative Care Non-Covered India Company Non-Covered Preventative Care Non-Covered India Company Non-Covered India Company Non-Covered Preventative Care Non-Covered India Company Non-Covered	Nor Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Not Covered: Procedure/service reviewed against Medical Policy Criteria. Solemit for Recommended Clinical Review (Predetermination) to avoid post-service review. Not Criteria: Procedure/service reviewed against Medical Policy Criteria. Solemit for Recommended Clinical Review (Predetermination) to avoid post-service review. Not Criteria: Procedure/service reviewed against Medical Policy Criteria. Solemit for Recommended Clinical Review (Predetermination) to avoid post-service review. Not Criteria: Procedure/service reviewed against Medical Policy Criteria. Solemit for Recommended Clinical Review (Predetermination) to avoid post-service review. Not Criteri			

A4553					
	Incontinence garment anytype	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
A4554	Non-Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
	Disposable underpads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
	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.	_	_	-
	Hyperbaric o2 chamber disps	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A4596	Ces system monthly supp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	_	Add effective 04/01/2023
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.	_	3/31/2023	Retire effective 03/31/2023
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.	_	_	_
A4639	Infrared ht sys replcmnt pad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A4641	Radiopharm dx agent noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
A4649	Surgical supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
	Repair/maint cont hemo equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
	Misc dialysis supplies noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	Non-sterile gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-
	Reusable oral thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Reusable rectal thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Modification diabetic shoe	Unlisted: Procedure/service not specifically defined or classified, maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A6261	Wound filler gel/paste /oz	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6262	Wound filler dry form / gram	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6512	Compres burn garment noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
A6549	G compression stocking	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	
	Single vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
	Multi-vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
			_		_
	Non-covered item or service Hot/cold botle/cap/col/wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Hot/cold botle/cap/col/wrap Monitoring feature/deviceNOC	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		-	-
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	Alert device noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
	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, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
A9291	Pres dig cog behav thera fda	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, maybe subject to contract/clinical review.	_	_	_
A9597	Pet dx for tumor id noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	Pet dx for non-tumor id noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	Non-rad contrast materialNOC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
	Radiopharm rx agent noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_		
	Supply/accessory/service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	DME supply or accessory nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		_
	Enteral supp not otherwise c	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
	Parenteral supp not othrws c	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
	Hemostatic agent gi topic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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.	_	_	_
C1764	Event recorder cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C1823	Gen neuro trans sen/stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
	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.			
	Cardiac monitor sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		
	Implant/insert device noc		_		
		Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	Wireless pressure sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	Brachytx stranded NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
	Brachytx non-stranded NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5272	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5273	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5274	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5275	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5276	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	_	Add effective 04/01/2023
C5277	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/2023
	Low cost skin substitute app	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/2023
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	., ., 2023		
C9257	Bevacizumab injection	required per contract agreement.	-	-	-
C9354	Veritas collagen matrix cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9356	TenoGlide tendon prot cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Dermal substitute native non-denatured collagen fetal				
					-
	bovine origin (SurgiMend Collagen Matrix) per 0.5	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	
	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters		-	-	
C9360	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
C9360 C9363	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal Integra Meshed Bil Wound Mat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
C9360 C9363 C9364	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	- -	-	
C9360 C9363 C9364 C9399	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
C9360 C9363 C9364 C9399 C9739	bovine origin Gurgil Mend Collagen Matrix) per 0.5 square centimeters Surgil Mend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals Cystoscopy prostatic imp 1-3	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted Procedure; May require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - -	
C9360 C9363 C9364 C9399 C9739	bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted Procedure; May require Prior Authorization per contract agreement.	- - - -	- - - -	-
C9360 C9363 C9364 C9399 C9739 C9740	bovine origin Gurgil Mend Collagen Matrix) per 0.5 square centimeters Surgil Mend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals Cystoscopy prostatic imp 1-3	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted Procedure; May require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		- - - -	
C9360 C9363 C9364 C9399 C9739 C9740	bovine origin GurgilMend Collagen Matrix) per 0.5 square centimeters SurgilMend neonatal integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals Cystoscopy prostatic imp 1-3 Cysto impl 4 or more	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Unlisted Procedure, May require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
C9360 C9363 C9364 C9399 C9739 C9740 C9757	bovine origin EurgiMend Collagen Matrix) per 0.5 square centimeters SurgiMend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals Cystoscopy prostatic imp 1-3 Cysto impl 4 or more Spine/lumbar disk surgery	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
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C9360 C9363 C9364 C9369 C9740 C9757 C9764 C9766 C9766 C9766 C9767 C9770 C9771 C9777 C9898	bovine origin Gurgildend Collagen Matrix) per 0.5 square centimeters Surgildend neonatal Integra Meehed Bil Wound Mat Porcine implant Permacol unclassified drugs or biologicals Cystoscopy prostatic imp 1-3 Cysto impl 4 or more Spine/lumbar disk surgery Revasc intrass lithotripsy Revasc intras lithotrip-stent Revasc intra lithotrip-stent Revasc intra lithotrip-stent Revasc intra lithotrip-stent Cysto when pros implant Vitree/mech pars subret inj Nal/sins cryo post natal tis Revasc lithotrip stent inj Nal/sins cryo post natal tis Revasc lithotrip tilloperene Revasc lithotr-stent tib/per Revasc lithotr-stent tib/per Revasc lithotr-stent tib/per Revasc lithotr-stent bil/per Revasc lithotr-stent bil/per Revasc lithotr-stent bil/per Revasc lithotr-stent bil/per	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Unlisted Procedure, May require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (
C9360 C9363 C9364 C9369 C9379 C9770 C9766 C9767 C9768 C9770 C9771 C9771 C9772 C9773 C9774 C9775 C9775 C9775 C99778 C99778 C99779 C99779 C9979 C9999	bovine origin GurgilMend Collagen Matrix) per 0.5 square centimeters SurgilMend neonatal Integra Meshed Bil Wound Mat Porcine implant Permacol unclassified druger biologicals Cystoscopy prostatic imp 1-3 Cysto impl 4 or more Spine/lumbar disk surgery Revasc intras lithotripsy Revasc intra lithotrip-stent Revasc intra lithotrip-stent Revasc intra lithotrip-stent Endo us-guide hep porto grad Cysto w/temp pros implant Vitrec/mech pars subret inj Nal/sins cryo post nasla tis Revasc lithotrip-tip tip/perone Revasc lithotrip-tip bip/perone Revasc lithotris-tent tib/per Revasc lithotris-tent tib/per Revasc lithotris-tent tib/per Revasc lithotris-tent tib/per Esophag mus integs w/eso egd Inpnt stay radiolabeled item	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). Unlisted Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review			

D1706	Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im Dose 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
D1999	unspecified preventive procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D2999	unspecified restorative procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
D3999	unspecified endodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D4999	unspecified periodontal procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
D5899	unspecified removable prosthodontic procedure by	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D5999	unspecified maxillofacial prosthesis by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
D6199	unspecified implant procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	
D6999	unspecified fixed prosthodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
	extraction erupted tooth requiring removal of bone				
D7210	and/or sectioning of tooth and including elevation of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
D7230	removal of impacted tooth - partially bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_	
D7999	unspecified oral surgery procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_	
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
D8999	unspecified orthodontic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
D9999	unspecified adjunctive procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
E0183	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.			
E0210	Electric heat pad standard	Non Covered: Procedure/service not covered by the Plan. Not subject to per-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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
E0218					_
E0221 E0231	Infrared heating pad system Wound warming device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
E0231	Wound warming device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
E0232	Warming card for NWT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
E0236 E0240	Pump for water circulating p	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	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	Pediatric Crib Hospital Grade Fully Enclosed With Or Without Top Enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_		-
E0446	Topical Ox Deliver sys nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
		MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
E0485	Oral device/appliance prefab	required per contract agreement.	-	-	=
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.	_	_	_
E0487	Electronic spirometer	Tecumes per contracts operations. EU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
E0616	Cardiac event recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		
E0625	Patient lift bathroom or toi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
E0635	Patient Lift Electric With Seat Or Sling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
	Combination Sit To Stand Frame/Table System Any Size	The Citizens in recovered against viscolar foliage citizens. Journal of recommended climate interest in recovering pass series review.			_
E0637	Including Pediatric With Seat Lift Feature With Or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	=
	Without Wheels Standing Frame/Table System One Position (E.G.				
E0638	Upright Supine Or Prone Stander) Any Size Including	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	Pediatric With Or Without Wheels				
E0641	Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
	Or Without Wheels	The Citation in decoding a citation of the citation of the citation in the citation in the citation of the cit	-	-	-
E0642	Standing Frame/Table System Mobile (Dynamic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0650	Stander) Any Size Including Pediatric Pneuma compresor non-segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
E0651				_	
E0652	Pneum compressor segmental 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0655	Pneum compres w/cal pressure Pneumatic appliance half arm		-	_	_
E0656	Preumatic appliance half arm Segmental pneumatic trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	_
E0656				_	_
E0657	Segmental pneumatic chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E0665	Pneumatic appliance full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	Pneumatic appliance full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
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.		_	_
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.	-	-	
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.	-	_	_
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.	_	_	
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.	_	_	_
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.	_	_	_
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.	_	_	_
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.	_	_	_
E0675	Pressure pneum appl half leg Pneumatic compression device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
E0676	Pressure pneum appl half leg Pneumatic compression device 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- -	_ 	- - -
E0676 E0691	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS UVI 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -	- - -	-
E0676 E0691 E0692	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pril 2 sg ft or less 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - -	- - - -
E0676 E0691 E0692 E0693	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - - -	- - - -
E0676 E0691 E0692 E0693 E0694	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft 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. BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - - -	-
E0676 E0691 E0692 E0693 E0694	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (ICPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - -	-	-
E0676 E0691 E0692 E0693 E0694 E0740	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft 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. BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - -	-
E0676 E0691 E0692 E0693 E0694 E0740 E0747	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl md cabinet sys 6 ft Non-implant pelv fir e-stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (ICPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	
E0676 E0691 E0692 E0693 E0694 E0740	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pril 2 sg ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl md cabinet sys 6 ft Non-implant pelv fir e-stim 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - - - - -	-
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760 E0761	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pni 2 sg ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl mc dabinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - - - - - -	
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl md cabinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimittor Nontherm electromgntc device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		- - - - - - - - - - -	
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760 E0761	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pni 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Ovn-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor Nontherm electromgntc device Trans elec jt stim dev sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (ICPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (IPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (IPCP).	-		
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760 E0761 E0762 E0764	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pril 2 spt for less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl sys panel 6 ft Uvl mc abbinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor Nontherm electromgntc device Trans elec jr, stim dev sys Functional neuromuscularstim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recomm	-		
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760 E0761 E0762 E0764 E0766	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pni 2 sg ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl mic acbinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor Nontherm electromght device Trans elec jt stim dev sys Functional neuromuscularstim Elec stim cancer treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, wh		_	-
E0676 E0691 E0692 E0693 E0694 E0740 E0747 E0760 E0761 E0762 E0764 E0766 E0769	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl mic abinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor Nontherm electromgntc device Trans elec it stim dev sys Functional neuromuscularatim Elec stim cancer treatment Electric wound treatment dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review		_	-
E0676 E0691 E0692 E0693 E0694 E0740 E0761 E0761 E0762 E0764 E0766 E0769 E0769	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl sys panel 4 ft Uvl sys panel 6 ft Ovseries ft Non-implant pelv ftr e-stim Elec osteogen sitm not spine Osteogen uitrasound stimittor Nontherm electromgint device Trans elec jt stim dev sys Functional neuromuscularistim Elec stim cancer treatment Elects im cancer treatment Electric wound treatment dev Functional electric stim NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (ICPP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		_	-
E0676 E0691 E0692 E0693 E0693 E0693 E0694 E0740 E0747 E0760 E0761 E0762 E0764 E0769 E0770	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pril 2 spt for less Uvl sys panel 4 ft Uvl sys panel 6 ft Uvl sys panel 6 ft Uvl sys panel 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrasound stimitor Nontherm electromgntc device Trans elec jt; stim dev sys Functional neuromuscularstim Elec stim cancer treatment Electric wound treatment dev Functional electric stim NOS Functional electric stim NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU poli		_	-
E0676 E0691 E0692 E0693 E0693 E0694 E0747 E0760 E0761 E0762 E0764 E0766 E0769 E0770 E0830	Pressure pneum appl half leg Pneumatic compression device Inter limb compress dev NOS Uvl pnl 2 sq ft or less Uvl syp panel 4 ft Uvl syp panel 6 ft Uvl mid cabinet sys 6 ft Non-implant pelv fir e-stim Elec osteogen stim not spine Osteogen ultrawound stimitor Nontherm electromgntc device Trans elec it stim dev sys Fructional neuromuscularstim Elec stim cancer treatment Electric wound treatment dev Functional electric stim NOS Functional electric stim NOS Ambulatory traction device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU po		_	-

E0850	Traction stand free standing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_		_
E0855	Cervical traction equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
E0856	Cervic collar w air bladders	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
E0860	Tract equip cervical tract	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
E0890	Traction frame attach pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-		
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E0936	CPM device other than knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	
E0942	Cervical head harness/halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
E0944	Pelvic belt/harness/boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
E0985	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.			
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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.	-	_	-
E1002	Pwr seat tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
E1003	Pwr seat recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.			
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.			
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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.	-	-	-
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.	-	-	_
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.	_	_	_
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.			
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.	_		-
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.	_	_	_
E1161	Manual Adult Size Wheelchair Includes Tilt In Space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E1229	Pediatric wheelchair NOS	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
E1239	<u> </u>		_	_	-
	Ped power wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
E1399	Durable medical equipment mi	Unlisted: Procedure/service not specifically defined or classified, maybe 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.		_	
E1632	Wearable artificial kidney	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	
E1699	Dialysis equipment noc	Unlisted: Procedure/service not specifically defined or classified. maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).	-		-
E1701	Repl cushions for jaw motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
E1702	Repl measr scales jaw motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
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.	_		
E2301	Pwr standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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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.	_	_	_
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.	_	_	_
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.	_	_	_
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.		_	_
E2321	Hand interface joystick	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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E2322	Mult mech switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2323	Special joystick handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2324	Chin cup interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.			
E2326					_
	Breath tube kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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.	_	_	_
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.	_	_	_
E2329	Head control nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.			
E2331	Attendant control				_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
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.		_	_
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.		_	_
E2341 E2342	W/c wdth 24-27 in seat frame 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
	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.	-	-	_
E2342 E2343	W/c dpth 20-21 in seat frame 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -	- - -	
E2342 E2343 E2351	W/c dpth 20-21 in seat frame W/c dpth 22-25 in seat frame Electronic SGD interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			- - -
E2342 E2343 E2351 E2373	W/c dpth 20-21 in seat frame W/c dpth 22-25 in seat frame Electronic SGD interface 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -		
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E2342 E2343 E2351 E2373 E2374	W/c dpth 20-21 in seat frame W/c dpth 22-25 in seat frame Electronic SGD interface Hand/chin ctrl spec joystick 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		
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	Alcohol And/Or Substance (Other Than Tobacco) Misus	se e			
G2011	Structured Assessment (E.G. Audit Dast) And Brief	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-
G2082	Intervention 5-14 Minutes 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.			
G2082 G2083			_		-
	Visit esketamine > 56m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		
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 externity neur exam docum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		_
G8405	Low externity 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 ivef 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. 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. 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G8474 G8475		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	ACE/ARB thxpy not rx?d		-	-	-
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, maybe 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.	_		_
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 stgl no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9064	Onc dx nscic 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	One 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	One dx brst stg3-HR no pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			_
G9073	One dx brst stg3-noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9074 G9075	Onc dx brst metastic/ recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
G9073	One dx prostate T1no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
G9077	One dx prostate T2no progres One dx prostate T2no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9078 G9079			-	-	-
G9079 G9080	One div prostate T3b-T4noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	-
	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.			
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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.			
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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.			
G9120	Oncology; Disease Status; Limited To Multiple Myeloma	Non-covered. Procedure/service not covered by the Plan. Not sought to preservice review.	_	_	_
G9128	Systemic Disease; Smoldering Stage I (For Use In A	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
GJILO	Medicare-Approved Demonstration Project)	Notificative ear. Procedure/service not covered by the Plain. Not subject to pre-service review.	-	-	-
G9129		Non-Councid December (service and councid by the Disc. Not subject to any conjugation)			
	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 Ig 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.			_
	Outpatient Intravenous Insulin Treatment (OIVIT) either				
	pulsatile or continuous by any means guided by the				
G9147	results of measurements for:respiratory quotient;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
	and/or urine urea nitrogen (UUN); and/or arterial		-	-	-
	venous or capillary glucose; and/or potassium				
	concentration				
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, maybe subject to contract/clinical review.	_	_	_
H0047	Alcohol/drug abuse svc nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
	According abase section	MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	_	_	-
J0129	Abatacept injection	wir citeria. Proceduciyserice reviewed against weddar Folicy Criteria. Submit for recommended clinical neview (Fredetermination) to avoid post-service review. From Authorization may be required per contract agreement.	_	_	_
10172	Ini aducanumah-awwa 2 mg	MP Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for Recommended Clinical Review (Predetermination) to avoid post-service review			
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. MR Criteria: Procedure/service-reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
J0172 J0180	Inj aducanumab-avwa 2 mg Injection Agalsidase Beta 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	_	_	-
J0180	Injection Agalsidase Beta 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.	_	_	-
	<u> </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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	<u>-</u>	-	-
J0180 J0202	Injection Agalsidase Beta 1 Mg 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. 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.	_ _ _	-	-
J0180	Injection Agalsidase Beta 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	_ _ _	-	-
J0180 J0202	Injection Agalsidase Beta 1 Mg 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. 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. 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.	-	- -	-
J0180 J0202 J0219 J0220	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nopt 4mg Alglucosidase 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. 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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- -	- - -
J0180 J0202 J0219	Injection Agalsidase Beta 1 Mg Injection alemtuzumab 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. Prior Authorization may be required per contract agreement. 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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	-	- - - -
J0180 J0202 J0219 J0220 J0221	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nqpt 4mg Alglucosidase alfa injection 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. 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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
J0180 J0202 J0219 J0220	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nopt 4mg Alglucosidase alfa injection	MP Cifferia: 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. MP Cifferia: 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. MP Cifferia: 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. MP Cifferia: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Cifferia: 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. MP Cifferia: 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. MP Cifferia: 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.	- - - - -	-	-
J0180 J0202 J0219 J0220 J0221 J0222	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nqpt 4mg Alglucosidase alfa injection INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG Inj. patisiran 0.1 mg	MP Citreia: Proedure/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. MP Citreia: 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. MP Citreia: 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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. 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.	-	-	- - - -
J0180 J0202 J0219 J0220 J0221	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nqpt 4mg Alglucosidase alfa injection INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG	MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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.		- - - - -	- - - - -
J0180 J0202 J0219 J0220 J0221 J0222 J0223	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-napt 4mg Alglucosidase alfa injection INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG Inj. patisiran 0.1 mg Inj givosiran 0.5 mg	MP Citeria: Proedure/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. MP Citeria: Proedure/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. MP Citeria: Proedure/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. MP Citeria: Proedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Citeria: Proedure/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. MP Citeria: Proedure/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. MP Citeria: Proedure/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. MP Citeria: Proedure/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.	-	-	- - - - -
J0180 J0202 J0219 J0220 J0221 J0222 J0223 J0224	Injection Agalsidase Beta 1 Mg Injection alemtuzumab Inj aval alfa-nqpt 4mg Alglucosidase alfa injection INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG Inj. patisiran 0.1 mg	MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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. MP Cifteria: 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.	-	-	-
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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	_	_	_
14 225	F	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J1325	Epoprostenol injection	required per contract agreement.	-	-	-
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.			_
J1427	Inj. viltolarsen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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 new contract arrevement	_	_	_
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.			_
J1458	Injection Galsulfase 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-		-
J1551	Inj cutaquig 100 mg	required per contract agreement.	-	-	-
J1554	Inj. asceniv	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.	_	_	_
J1566	Immune globulin powder	required per contract, agreement. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
J1599	lvig non-lyophilized NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
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.	-	_	-
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.	_		_
J1729	Inj hydroxyprogst capoat nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	_	_
J1743	Idursulfase injection	WP CHERIA: PICKEURE/SERVICE reviewed against medical rollicy Criteria. Submit to Recommended childran Review (Predetermination) to avoid post-service review. Prior Audio/Ladion may be required per contract agreement.	-	-	-
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			
14745		required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J1746	Inj. ibalizumab-uiyk 10 mg	required per contract agreement.	-	-	-
J1786	Injection Imiglucerase 10 Units	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.	_	_	_
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. Prior Authorization may be			
	iiij. iiiebiiizdiiiab-cdoii 1 iiig	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	-	-
J1931	Injection Laronidase 0.1 Mg	WP CHERIA: PICKEURE/SERVICE reviewed against medical rollicy Criteria. Submit to Recommended childran Review (Predetermination) to avoid post-service review. Prior Audio/Ladion may be required per contract agreement.	-	-	-
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.	_	_	_
J1954	Leuprolide depot cipla 7.5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023		Add effective 04/01/2023
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			
	Tiennekide inicakion	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J2278	Ziconotide injection	required per contract agreement.	-	-	-
J2327	Inj risankizumab-rzaa 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.	-	_	_
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. Prior Authorization may be			
	ing receptioning the service and	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	-	-
J2357	Omalizumab injection	WP CHERIA: PICKEURE/SERVICE reviewed against medical rollicy Criteria. Submit to Recommended childran Review (Predetermination) to avoid post-service review. Prior Audio/Ladion may be required per contract agreement.	-	-	-
J2440	Injection Papaverine Hcl Up To 60 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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			
J2503	Pegaptanib sodium injection	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
	3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J2507	INJECTION PEGLOTICASE 1 MG	required per contract agreement.	-	-	-
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.	_		
J2778	Injection Ranibizumab 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
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.			_
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.	-	-	-
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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-		-
J3032	Inj. eptinezumab-jjmr 1 mg	required per contract agreement.	-	-	-
J3060	Injection Taliglucerace Alfa 10 Units	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.	_	_	_
J3121	Inj testostero enanthate 1mg	required per Communic agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
15121	inj testostero enantriate 1mg	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-	_	-
J3145	Testosterone undecanoate 1mg	MP Chteria: Procedure/service reviewed against Medical Policy Chteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	-		
J3245	Inj. tildrakizumab 1 mg	required per contract agreement.	-	-	-
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	_	_	_
J3285	*	required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
	Treprostinil injection	required per contract agreement.	-	-	-
J3299	Inj xipere 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
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.	_		
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.	_	_	-
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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J3385	Injection Velaglucerase Alfa 100 Units	required per contract agreement.	-	-	-
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.	_	_	_
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. NB Criteria Submit for Recommended Clinical Bosion (Bradesceninstics) to suid and contract engine cosine. Dries Authorisation may be	-	-	-
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.	-	-	=
J3490	Drugs unclassified injection	Unlisted Procedure; May require Prior Authorization per contract agreement.			_
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.	_	_	
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; May require Prior Authorization per contract agreement.			
J3591	Esrd on dialysi drug/bio noc	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
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 remained nor contract argreement		_	_
J7192	Factor viii recombinant NOS	required per contract agreement. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
J7195	Factor ix recombinant nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
J7199	Hemophilia clot factor noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
J7309	Methyl Aminolevulinate (Mal) For Topical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
	Administration 16.8% 1 Gram		-	-	-
J7316	Injection Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MB Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	-
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.	-	-	-
J7402	Mometasone sinus sinuva	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
J7599	Immunosuppressive drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe 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, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7607	Levalbuterol comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7609	Albuterol comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7610	Albuterol comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7615	Levalbuterol comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7622	Beclomethasone comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
J7624	Betamethasone comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7627	Budesonide comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_

J7628	Bitolterol mesylate comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7629	Bitolterol mesylate comp unt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
J7632					-
	Cromolyn sodium comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-		-
J7634	Budesonide comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
J7635	Atropine comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
J7636	Atropine comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7637	Dexamethasone comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7638	Dexamethasone comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7640	Formoterol comp unit				-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
J7641	Flunisolide comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-		-
J7642	Glycopyrrolate comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7643	Glycopyrrolate comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7645	Ipratropium bromide comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7647	Isoetharine comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7650	Isoetharine comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
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J7657	Isoproterenol comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-		-
J7660	Isoproterenol comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
J7667	Metaproterenol comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
J7670	Metaproterenol comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7676	Pentamidine comp unit dose	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
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J7680	Terbutaline sulf comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7681	Terbutaline sulf comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7683	Triamcinolone comp con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
J7684	Triamcinolone comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
J7685	Tobramycin comp unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
J7699					
	Inhalation solution for DME	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		-	-
J7799	Non-inhalation drug for DME	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
J7999	Compounded drug noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
J8498	Antiemetic rectal/supp NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
J8499	Oral prescrip drug non chemo	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
J8597					
	Antiemetic drug oral NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
J8999	Oral prescription drug chemo	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
J9020	Asparaginase NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	_
J9285	Inj olaratumab 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4	4/1/2023	Retire effective 03/31/2023
J9285	Inj olaratumab 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_	
J9332	-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
J9332	Inj efgartigimod 2mg	required per contract agreement.	-	-	-
J9600	Porfimer sodium injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
J9999	Chemotherapy drug	Unlisted Procedure; May require Prior Authorization per contract agreement.			
K0005	Ultralightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
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K0010	Stnd wt frame power whichr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
K0011	Stnd wt pwr whichr w control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
K0012	Ltwt portbl power whichr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0013	Custom power whichr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
K0014	Other power whichr base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
K0053				_	-
	Elevate footrest articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
			-	_	
K0065	Spoke protectors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
K0108	Spoke protectors 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- -
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K0108 K0455	W/c component-accessory NOS Pump uninterrupted infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- - -
K0108 K0455 K0800	W/c component-accessory NOS Pump uninterrupted infusion 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0108 K0455 K0800 K0801	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	-	-
K0108 K0455 K0800 K0801 K0802	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs POV group 1 hd 301-450 lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - -	- - - -	- - - -
K0108 K0455 K0800 K0801 K0802 K0806	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - -	-	- - - - - -
K0108 K0455 K0800 K0801 K0802	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs POV group 1 hd 301-450 lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - -	-	-
K0108 K0455 K0800 K0801 K0802 K0806	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs POV group 1 hd 301-450 lbs POV group 1 hd 451-600 lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- - - - - - -
K0108 K0455 K0800 K0801 K0802 K0806 K0807	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 3000lbs POV group 1 hd 301-450 lbs POV group 1 vhd 451-600 lbs POV group 2 vhd up to 3000lbs POV group 2 bd up to 3000lbs POV group 2 bd 301-450 lbs 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- - - - - - -
K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs POV group 1 std up to 300lbs POV group 1 whd 451-600 lbs POV group 2 std up to 300lbs POV group 2 td up to 300lbs POV group 2 td 451-600 lbs POV group 2 vd 4451-600 lbs Pow group 2 vd 4451-600 lbs Power operated vehicle NOC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			- - - - - - - -
K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808 K0812 K0813	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 300lbs POV group 1 hd 301-450 lbs POV group 1 hd 451-600 lbs POV group 2 std up to 300lbs POV group 2 std up to 300lbs POV group 2 hd 301-450 lbs POV group 2 hd 451-600 lbs POV group 2 hd 451-600 lbs POW group 3 hd 451-600 lbs Power operated vehicle NOC 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			- - - - - - - - -
K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808 K0812 K0813	W/c component-accessory NOS Pump uninterrupted infusion POV group 1 std up to 3000lbs POV group 1 hd 301-450 lbs POV group 1 hd 451-600 lbs POV group 2 std up to 300lbs POV group 2 hd 301-450 lbs POV group 2 hd 451-600 lbs POV group 2 std 451-600 lbs POW group 2 std 451-600 lbs POW group 3 std port saythack 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		- - - - - - - - - -
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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.			
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.	_	_	-
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.	_	_	-
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.	_	_	_
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.	_	_	_
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.			
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.			-
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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.	_	_	_
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.	_	_	_
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.	_	_	_
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.			
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.			-
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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.	_	_	_
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.	_	_	_
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.	_	_	_
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.			
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.			_
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K0898	Power wheelchair NOC	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
K1002	Ces system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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, which is one of our Clinical Payment and Coding Policy (CPCP).			-
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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, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
K1009	Speech volume modulation sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
K1018	Ext up limb tremor stim wris	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
K1019	Supp ext up limb tremor stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
K1020			_	_	-
	Non-invasive vagus nerv stim	MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
K1023	Trans elec nerv periph nerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
K1025	Non pneum compress full arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
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			
	oral dev without fix mech	required per contract agreement.	-	-	=
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.			
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, which is one of our Clinical Payment and Coding Policy (CPCP).			
K1032	Non pneum seq comp full leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
K1032			_	-	-
	Non pneum seq comp half leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
L0999	Add to spinal orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_		_
L1499	Spinal orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
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, maybe 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, maybe subject to contract/clinical review.		_	
L3999			_	_	-
	Upper limb orthosis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	-	_	-
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.	_	_	_
L5999	Lowr extremity prosthes NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
	Part hand myo excluterm dev	MP Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for Recommended Clinical Review (Predetermination) to avoid nost-service 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.	-	_	_
L6026 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
L6611	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC		-	-	-
	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS		-		
L6611	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
L6611	Additional switch ext power 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6880 L6920	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTOR(S) Wrist disarticul switch ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6880 L6920 L6925	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS) Wrist disarticul switch ctrl Wrist disart	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6880 L6920 L6925 L6930	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS! Wrist disarticul switch tri Wrist disarticul switch tri Below elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -	-	-
L6880 L6920 L6925	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS) Wrist disarticul switch ctrl Wrist disart	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6880 L6920 L6925 L6930	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS! Wrist disarticul switch tri Wrist disarticul switch tri Below elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6611 L6880 L6920 L6925 L6930 L6935	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS) Wrist disarticul switch crit Wist disart myoelectronic c Below elbow switch control Below elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	
L6611 L6880 L6920 L6925 L6930 L6935	Additional switch ext power ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTORIS Wrist disarticul switch ctrl Wrist disart myselectronic c Below elbow switch control Below elbow myselectronic ct Elbow disarticulation switch Elbow disarticulation switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- - - - - -
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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	_	_		
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L8619	Coch Imp Ext Proc/Contr Rplc	required per contract agreement.	-	-	-	
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.	_	_	_	
L8622	Repl Alkaline Battery	required per contract, agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be				
10022	repraisance battery	required per contract agreement.	-	-	-	
L8623	Lith Ion Batt Cid Non-Earlyl	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.	_	_	-	
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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be				
L8627	Cid Ext Speech Process Repl	INFO CITETAL PROCESSES AND EXPENSES AND ACCOUNTS OF THE PROCESS AND ACCOUNTS OF THE PR	-	-	=	
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				
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L8629	Cid Transmit Coil And Cable	required per contract agreement.	-	-	=	
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	_	_		
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L8691	Aoi Snd Proc Repl Excl Actua	required per contract agreement.	-	-	-	
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	_	_		
L8699	Prosthetic implant NOS	required per contract agreement. Unlisted: Procedure/service not specifically defined or classified, maybe 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.			-	
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.	_		_	
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	
M0076						
P2031	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-	
	Hair analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-		
P9020	Plaelet rich plasma unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_		
P9099	Blood component/product noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	
Q0507	Misc sup/acc ext VAD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	
Q0508	Misc sup/acc imp VAD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	
Q0509	Mis sup/ac imp VAD nopay med	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	-	-	_	
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.	_			
Q2039	Influenza virus vaccine nos	Unlisted: Procedure/service not specifically defined or classified, maybe 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 nor contract arrangement	-	-	-	
Q2042	Tisagenlecleucel car-pos t	required per contract agreement. 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.	-	-	-	
Q2050	Doxorubicin inj 10mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_	
Q2052	Ivig demo services/supplies	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	
Q2053	Brexucabtagene 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.	_	_	_	
Q2054	Providence of the control of the con	require per contract, agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be				
Q2054	Lisocabtagene mara car pos t	required per contract agreement.	-	-	-	
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.	_	_	_	
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.	-	-	-	
Q4050	Cast supplies unlisted	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	
Q4051	Splint supplies misc	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	-	_	
Q4100	Skin substitute NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_		
Q4100 Q4101	Skin substitute NOS Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- -	-	- -	
Q4100 Q4101 Q4102	Skin substitute NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - -	- - -	
Q4100 Q4101 Q4102 Q4103	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - -	- - - -	
Q4100 Q4101 Q4102 Q4103 Q4104	Skin substitute NOS Apligraf Oasis wound matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	- - - -	-		
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	- - - - -	- - - - -	
Q4100 Q4101 Q4102 Q4103 Q4104	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-		
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra drt or omnigraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-	
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra drt or omnigraft Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-	
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110	Skin substitute NOS Apligraf Oasis wound matrix Oasis brun matrix Integra BMWD Integra dir to rounigraft Dermagraft Graftjacket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-	
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra drt or omnigraft Dermagraft Graftjacket Integra matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - - - -	-		
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix integra BMWD Integra drt or omnigraft Dermagraft Graftjacket Integra matrix Primatrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-	
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110 Q4111	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra drt or omnigraft Dermagraft Graftjacket Integra matrix Primatrix Gammagraft Gammagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP).				
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110 Q4111 Q4112	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra drf or omnigraft Dermagraft Graftjacket Integra matrix Primatrix Graftjacket Cymetra injectable	MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).				
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110 Q4111 Q4112 Q4113	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra dri or omnigraft Dermagraft Graftjacket Integra matrix Primatrix Gammagraft Cymeta injectable Graftjacket xpress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
Q4100 Q4101 Q4102 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4110 Q4111 Q4112 Q4113 Q4114	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra BMWD Integra drt or omnigraft Dermagraft Graftjacket Integra matrix Primatrix Gammagraft Cymetra injectable Graftjacket vpress Integra flowable wound matri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4100 Q4101 Q4102 Q4103 Q4103 Q4104 Q4105 Q4106 Q4107 Q4108 Q4100 Q4111 Q4112 Q4113 Q4114 Q4115 Q4115 Q4116 Q4117	Skin substitute NOS Apligraf Oasis wound matrix Oasis burn matrix Integra BMWD Integra dri or omnigraft Dermagraft Graftjacket Integra matrix Primatrix Gammagraft Gymeta injectable Graftjacket kyress Integra flowable wound matri Alloskin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject t				
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Commence per again and County Prince of the County	Q4233 Q4234 Q4235 Q4236 Q4237 Q4238 Q4239 Q4240 Q4241 Q4242 Q4242 Q4244 Q4245 Q4246 Q4247	Corplex per sq cm Surfactor /nudyn per 0.5 cc Xcellerate per sq cm Amniorepair or altiply sq cm Carepatch per sq cm Cryo-cord per sq cm Demr-maxx per sq cm Amnio-maxx or lite per sq cm Corecyte topical only 0.5 cc Polycyte topical only 0.5 cc Amniocyte plus per 0.5 cc Procenta per 200 mg Amniotext per cc Corretext or protext per cc Corretext or protext per cc Amniotext patch per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not rei			
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Q4250	Amnioamp-mp per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4252	Vendaje per square centimet	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
Q4253			_	_	-
	Zenith amniotic membrane psc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4254	Novafix dl per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4255	Reguard topical use per sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4256	Mlg complet per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4257	Relese per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4258					-
	Enverse per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
Q4259	Celera per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4260	Signature apatch per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4261	Tag per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4262	Dual layer impax per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023		Add effective 01/01/2023
Q4263	Surgraft tl per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
Q4264	Cocoon membrane per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
Q5009	Hospice care NOS	Unlisted: Procedure/service not specifically defined or classified, maybe 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			
Q3103	injection innection	required per contract agreement.	_	_	-
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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
Q5106	Inj retacrit non-esrd use	wir Citella. Foldeut/get wie Terrewed against weuten Foldy Citella. Journal of Recommended Cinical Newwork (Federal mindor) to avoid post-service Terrew. From Authorization may be required per contract agreement.	-	-	-
O5109	1.1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be			
Q5109	Injection ixifi 10 mg	required per contract agreement.	-	-	-
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.	_	_	_
S0013	Esketamine nasal sprav	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
50117	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.	-	_	_
50157	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 new construct accommended and accommendation of the procedure/Service review.	_	_	_
	Prenatal vitamins 30 day	required per contract agreement.			
		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, maybe subject to contract/clinical review.	_	_	
50622	Phys exam for college	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
50800	Laser in situ keratomileusis		-	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
50810	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, maybe subject to contract/clinical review.			_
S1002	Custom item	Unlisted: Procedure/service not specifically defined or classified, maybe 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.			
52083	Adjustment gastric band				-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
S2112	Knee arthroscp harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2117	Arthroereisis subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S2118	Total hip resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S2120		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be	_	_	
32120	Low Density Lipoprotein(Ldl)	required per contract agreement.	-	-	-
52140	Cord blood harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
52142	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.			
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.	_		
52202			_	_	-
	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
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.	_	_	_
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.	_	_	_
S2300	Arthroscopy shoulder surgi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S2409	Fetal surg noc	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	
52422	Surgical Techniques Requiring Use Of Robotic Surgical	wir Citteria. Procedure/service reviewed against weditair Policy Citeria. Submit for Nectonimended clinical neview (Fredetermination) to avoid post-service review.	_	_	-
S2900		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
	Procedure)		_	_	-
S3600	Stat lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
53601	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, which is one of our Clinical Payment and Coding Policy (CPCP).			-
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S3652	Saliva test hormone level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
S3900	Surface EMG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
S4015	Complete IVF nos case rate	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_		_
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.	_		-
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S4026	Procure donor sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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.	-	_	_
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.			
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.	_	_	
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.	_	_	
54990	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.	_	_	_
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S5036	Hit Device Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	
S5036 S5100	Adult daycare services 15min		_	_	
55100	Adult daycare services 15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5100 S5101	Adult daycare services 15min Adult day care per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	<u>-</u> -	-
S5100 S5101 S5102	Adult daycare services 15min Adult day care per half day Adult day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	
\$5100 \$5101 \$5102 \$5105	Adult daycare services 15min Adult day care per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
S5100 S5101 S5102	Adult daycare services 15min Adult day care per half day Adult day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			- - - -
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\$5100 \$5101 \$5102 \$5108 \$5108 \$5108 \$5109 \$5110 \$5111 \$5115 \$5116 \$5120 \$5120 \$5121 \$5125 \$5126 \$5130 \$5130 \$5130 \$5130	Adult daycare services 15min Adult day care per half day Adult day care per half day Adult day care per half day Adult day care per diem Centerbased day care perdiem Homecare train pt 15 min Homecare train pt 15 min Homecare train pt session Family homecare train/sessio Nonfamily homecare train/15m Nonfamily HC train/session Chore services per 15 min Chore services per 15 min Chore services per 6 min Attendant care service / 15m Attendant care service / 6/16m Homaker service nos per 15m Homemaker service nos per 15m Adult companioncare per 15m Adult companioncare per 15m Adult companioncare per 6me Adult foster care per 6me	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. 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.	_	_	_
55181	HH respiratory thrpy nos/day	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
S5185	Med reminder serv per month				-
S5199	· · · · · · · · · · · · · · · · · · ·	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-
	Personal care item nos each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	
S5497	HIT cath care noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
S8130	INTERFERENTIAL CURRENT STIMULATOR 2 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
S8131	INTERFERENTIAL CURRENT STIMULATOR 4 CHANNEL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
58189			_		-
	Trach supply noc	Unlisted: Procedure/service not specifically defined or classified, maybe 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, maybe 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.			
S8940	Hippotherapy per session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
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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.	-	-	-
S8990	Pt or manip for maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_		_
59001	Home uterine monitor with or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
59056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
59090	Vertebral axial decompressio	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
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59117	Back school visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
59125	Respite care in the home p	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	=
59335	HT hemodialysis diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
59379	HIT noc per diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
59381	HIT high risk/escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
59436					
	Lamaze class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-
59437	Childbirth refresher class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
59438	Cesarean birth class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
59439	VBAC class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
59442	Birthing class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
59444	Parenting class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
59445			_	_	-
	PT education noc individ	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_
59447	Infant safety class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
59449	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.			
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59454	Stress mamt class	Non Covered: Procedure (service not covered by the Plan. Not subject to pre-service review			
59454	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.		-	_
S9472 S9482		· · · · · · · · · · · · · · · · · · ·		- - -	
59472	Cardiac rehabilitation progr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
S9472 S9482	Cardiac rehabilitation progr Family stabilization 15 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		- - -
S9472 S9482 S9542 S9558	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
\$9472 \$9482 \$9542 \$9558 \$9562	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj growth horm diem HT inj plativizumab diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
\$9472 \$9482 \$9542 \$9558 \$9562 \$9810	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj growth horm diem HT inj galwizumab diem HT pharm per hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: 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, maybe subject to contract/clinical review.			-
\$9472 \$9482 \$9542 \$9558 \$9562 \$9810 \$9900	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj procyte diem HT inj palvizumab diem HT pharm per hour Christian Sci Pract visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
\$9472 \$9482 \$9542 \$9558 \$9562 \$9810	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj growth horm diem HT inj galwizumab diem HT pharm per hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: 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, maybe subject to contract/clinical review.			-
\$9472 \$9482 \$9542 \$9558 \$9562 \$9810 \$9900	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj procyte diem HT inj palvizumab diem HT pharm per hour Christian Sci Pract visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
\$9472 \$9482 \$9542 \$9558 \$9562 \$9810 \$9900 \$9970	Cardiac rehabilitation progr Family stabilization 15 min HT inj noc per diem HT inj growth horm diem HT inj palvizumab diem HT planivzumab diem HT pharm per hour Christian 5G Pract visit Health club membership yr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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, maybe subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-
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