

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

Posted June 2023

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

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT\*) and/or Healthcare Common Procedure Coding System (HCPCS) codes that, based on our medical policy, are:
- Subject to a medical necessity review,

- Candidates for a Recommended Clinical Review (Predetermination),

- Not a benefit for our members,

- Considered experimental, investigational and unproven (EIU), or

- Not on our prior authorization list (with some exceptions based on members' benefit plans)

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

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

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

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

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

			Theating	Ending	
Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	ANESTH SPINE MANIPULATION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	Date	Date	
00797	ANESTH SURGERY FOR OBESITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
07957	Weight Loss	Non Covered: Proceedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
11200	REMOVAL OF SKIN TAGS <w 15<="" td=""><td>Non Covered: Proceedings where not covered by the Plan. Not subject to pre-service review.</td><td>-</td><td>-</td><td>-</td></w>	Non Covered: Proceedings where not covered by the Plan. Not subject to pre-service review.	-	-	-
11200	REMOVE SKIN TAGS ADD-ON	Non Covere: Proceeding/service not covered by the Plan. Not subject to pre-service review.	-	-	-
11201	Correct Skin Color 6.0 Cm/<	Mill Conference Proceedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
11920	Correct Skill 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.		-	
11921	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.		-	
11922	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.		-	
11950	TX CONTOUR DEFECTS 1 CC/<			-	-
		MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
11952	TX CONTOUR DEFECTS 5.1-10CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
11954	TX CONTOUR DEFECTS >10.0 CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
11960	INSERT TISSUE EXPANDER(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
11970	RPLCMT TISS XPNDR PERM IMPLT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
11980	IMPLANT HORMONE PELLET(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	– Add effective
15271	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	-	04/01/2023
15272	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 04/01/2023
15273	Skin Sub Grft 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 04/01/2023
15274	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 04/01/2023
15275	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 04/01/2023
15276	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 04/01/2023
15277	Skn Sub Grft 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 04/01/2023
15278	Skn Sub Grft F/N/Hf/G Ch 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 04/01/2023
15758	FREE FASCIAL FLAP MICROVASC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
15769	GRFG AUTOL SOFT TISS DIR EXC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
15771	GRFG AUTOL FAT LIPO 50 CC/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
15772	GRFG AUTOL FAT LIPO EA ADDL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
15775	HAIR TRNSPL 1-15 PUNCH GRFTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
15776	HAIR TRNSPL >15 PUNCH GRAFTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
15780	DERMABRASION TOTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15781	DERMABRASION SEGMENTAL FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15782	DERMABRASION OTHER THAN FACE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	_
15783	DERMABRASION SUPREL ANY SITE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15786	ABRASION LESION SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15787	ABRASION LESIONS ADD-ON	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15788	CHEMICAL PEEL FACE EPIDERM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15789	CHEMICAL PEEL FACE DERMAL	MP Criteria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
15792	CHEMICAL PEEL NORFACIAL	MP Criteria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15793	CHEMICAL PEEL NONFACIAL	MP Criteria: Procedure/service reviewed against medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15820	REVISION OF LOWER EYELID	MP Criteria. Procedure/service reviewed against medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15820	REVISION OF LOWER EYELID	MP Criteria: Procedure/service reviewed against medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	
15822	REVISION OF LOWER EYELID REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Linical Review (Predetermination) to 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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15823	REVISION OF UPPER EYELID	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-

15824					
	REMOVAL OF FOREHEAD WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
45035		contract agreement.	-	-	-
15825	REMOVAL OF NECK WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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	-	-	-
15826	REMOVAL OF BROW WRINKLES	wind there a not contract against medical noise strategies and the continent of recommended clinical review (neucerinitation) to avoid post-service review. Prior Autorization may be required per contract agreement.	-	-	-
15828	REMOVAL OF FACE WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
15829	REMOVAL OF SKIN WRINKLES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
15830	EXC SKIN ABD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
15832	EXCISE EXCESSIVE SKIN THIGH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
15833	EXCISE EXCESSIVE SKIN LEG	mm Checkan Spectra Checkan Spectra Spectra Spectra Spectra Chical Review (Predestimination) to avoid post-service review. MM Chickan Spectra Chical Spectra S	-	-	-
15835			-	-	-
	EXCISE EXCESSIVE SKIN HIP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
15835	EXCISE EXCESSIVE SKIN BUTTCK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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.	-	-	_
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.			
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.	-	-	-
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.	-	-	-
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.	_		_
		MP Criteria: Procedure/service reviewed against Medical Poly Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	-	-	-
19316	SUSPENSION OF BREAST	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			_
19325	BREAST AUGMENTATION W/IMPLT	contract agreement.	-	-	
19323		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	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.	-	-	-
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	REVJ PERI-IMPLT CAPSULE BRST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		
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.	-	-	-
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	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU 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.			_
20555	UNLISTED PX MUSCSKEL GENERAL		_	-	_
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.	_	-	
		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.	-	-	_
21073	MNPJ OF TMJ W/ANESTH		-	-	-
21073 21089	MNPJ OF TMJ W/ANESTH UNLISTED MAXLFCL PROSTH PX	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.	-	- - -	-
21073 21089 21120 21121	MNPJ OF TMJ W/ANESTH UNLISTED MAXLFCL PROSTH PX RECONSTRUCTION OF CHIN	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.	- - - -	-	-
21073 21089 21120 21121 21122	MNPJ OF TMJ W/ANESTH UNLISTED MAKLFCL PROSTH PX RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - -	-
21073 21089 21120 21121 21122 21123	MNPJ OF TMJ W/ANESTH UNLISTED MAKLFCL PROSTH PX RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		- - - -
21073 21089 21120 21121 21122	MNPJ OF TMJ W/ANESTH UNLISTED MAKLFCL PROSTH PX RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - -	- - - - - - - -	- - - - -
21073 21089 21120 21121 21122 21123	MNPJ OF TMJ W/ANESTH UNLISTED MAKLFCL PROSTH PX RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN RECONSTRUCTION OF CHIN	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. Prior Authorization may be required per 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	-	-	-
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22899	INSJ STABLI DEV W/O DCMPRN	EIU: Procedure/service not 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 SPINE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
22999	UNLISTED PX ABDOMEN MUSCSKEL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
23929	UNLISTED PROCEDURE SHOULDER		-	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
24300	MNPJ ELBOW UNDER ANES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
4999	UNLISTED PX HUMERUS/ELBOW	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_
25259	MANIPULATE WRIST W/ANESTHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
25999	UNLISTED PX FOREARM/WRIST	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
6340	MANIPULATE FINGER W/ANESTH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
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6341	MANIPULAT PALM CORD POST INJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
26989	UNLISTED PX HANDS/FINGERS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
27275	MANIPULATION OF HIP JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
27280	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.	-		-
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7599	UNLISTED PX FEMUR/KNEE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
7703	RECONSTRUCTION ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
7860	FIXATION OF ANKLE JOINT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
7899	UNLISTED PX LEG/ANKLE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
8890	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).	-	-	-
8899	UNLISTED PX FOOT/TOES	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
9440	Addition Of Walker To Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
9799	UNLISTED PX CASTING/STRPG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
9866	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.	-	_	-
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9914	HIP ARTHRO W/FEMOROPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
9915	HIP ARTHRO ACETABULOPLASTY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
9916	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.	_	-	-
9999	UNLISTED PX ARTHROSCOPY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
0468	RPR NSL VLV COLLAPSE W/IMPLT		-	-	-
0406		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0469	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
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0999	UNLISTED PROCEDURE NOSE	Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
1299	UNLISTED PX ACCESSORY SINUS	Unlisted Procedure; May require Prior Authorization per contract agreement.	-	_	-
1599	UNLISTED PROCEDURE LARYNX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
1899	UNLISTED PX TRACHEA BRONCHI	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_		
2994	ABLATE PULM TUMOR PERO CRYBI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		
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2998	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.	-		-
2999	UNLISTED PX LUNGS & PLEURA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
3211	INSERT CARD ELECTRODES DUAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
3267	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.			
3268	EXCL LAA OPN OTH PX ANY METH		-	-	-
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3269	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.	-	-	-
3274	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.	_	-	-
3275	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.	-	-	_
3285	INSI SUBO CAR RHYTHM 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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3418	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
3419	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.	_	_	_
3999	UNLISTED PX CARDIAC SURGERY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
6299	UNLISTED PX VASCULAR NIX		-	_	-
		Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-
6465			-	_	
	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.	-	-	-
6466	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
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6468	NJX NONCMPND SCLRSNT MLT VN NJX SCLRSNT SPIDER VEINS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		_ _ _
6468 6470	NJX NONCMPND SCLRSNT MLT VN NJX SCLRSNT SPIDER VEINS 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -		- - -
6468 6470 6471	NIX NONCMPND SCLRSNT MLT VN NIX SCLRSNT SPIDER VEINS NIX SCLRSNT 1 INCMPTNT VEIN NIX SCLRSNT MLT INCMPTNT VN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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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6466 6468 66470 66471 66473 66473 66474 66475 66476 66478 66479	NIX NONCMPND SCIRSNT MLT VN NIX SCIRSNT SPIDER VEINS NIX SCIRSNT 1. INCMPTNT VEIN NIX SCIRSNT MLT INCMPTNT VN ENDOVENOUS MCHNCHEM 1ST VEIN ENDOVENOUS MCHNCHEM ADD-ON ENDOVENOUS RF 1ST VEIN 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. BU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). BU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EIU price, which is one of our Clinical Payment and Coding Policy (CPC). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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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468	NIX NONCMPND SCIRSNT MILT VN NIX SCIRSNT SPIDER VEINS NIX SCIRSNT 1 INCMPTNT VEIN ENDOVENOUS MCHNCHEM 1ST VEIN ENDOVENOUS MCHNCHEM ADD-ON ENDOVENOUS MCHNCHEM ADD-ON ENDOVENOUS MCHNCHEM ADD-ON ENDOVENOUS LASER VEIN ADDON ENDOVENOUS LASER VEIN ADDON STABY STIL CRT JUXTR 1 ACS PRQ AV FSTL CRT JUXTR 1 ACS PRQ AV FSTL CRT JUXTR 1 ACS TRANSCATH STENT CCA W/DES STENT PLACEMT ANTE CAROTID STENT PLACEMT ANTE CAROTID VASE EMBOLIZ/OCCLUDE VENOUS VASE EMBOLIZ/OCCLUDE VENOUS VASE EMBOLIZ/OCCLUDE DRGAN VASE EMBOLIZ/OCCLUDE DRGAN VASE EMBOLIZ/OCCLUDE DRGAN VASE EMBOLIZ/OCCLUDE DRGAN UNISTED VASC ENDOSCOPY PX REVISE LEG VEIN LIGATE JEG VEINS RADICAL LIGATE JEG VEINS STR 10-20 PHLEB VEINS - EXTREM 20+ REVISION OF LEG VEINS LEG UNLISTED PX ASCULAR SURGERY	MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. EU: Procedury/service not relimborade by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedury/service not relimborade by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post service review. MP Citaria: Procedury/service reviewed against Medical Policy Criteria. Submit for Recommended Clinica	1/1/2023 		- - - - - - - - - - - - - - - - - - -

38206	HARVEST AUTO STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-												
38207	CRYOPRESERVE STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_												
38208	THAW PRESERVED STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38209	WASH HARVEST STEM CELLS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_												
38210	T-CELL DEPLETION OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38211 38212	TUMOR CELL DEPLETE OF HARVST	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38212	RBC DEPLETION OF HARVEST PLATELET DEPLETE OF HARVEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38213	VOLUME DEPLETE OF HARVEST	WF Citeria: Froceburgsevice reviewed against Medical Policy Citeria. Submit for Recommendee Clinical Review (Predetermination) to avoid post-service review. MF Citeria: Froceburgsevice reviewed against Medical Policy Citeria. Submit for Recommendee Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38215	HARVEST STEM CELL CONCENTRIE	MP Criteria: Procedure/serve centerio against Medical Obj Cortieria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
38230	BONE MARROW HARVEST ALLOGEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	-	-	-												
		contract agreement.	-	-	-												
38232 38240	BONE MARROW HARVEST AUTOLOG	MP Criteria: Procedurg/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
	TRANSPLT ALLO HCT/DONOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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	-	-	-												
38241	TRANSPLT AUTOL HCT/DONOR	contract agreement.	-	-	-												
38242	TRANSPLT ALLO LYMPHOCYTES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-												
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 38589	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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-												
39499	UNLISTED PX MEDIASTINUM	Unlisted: Proceedingshive not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-												
39599	UNLISTED PX MEDIASTINOM	Unisted: Proceeding/Service not specifically defined or classified, maybe subject to contract/climital 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 41870	Removal Of Gum Tissue Gum Graft	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.	-	-	-												
41870	Gum Graft Repair Gum	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.	-	-	-												
41872	Repair Tooth Socket	Non Covered: Procedure/service inot covered by the Plan. Not subject to pre-service review.	-	_	-												
41899	UNLISTED PX DENTALVLR STRUX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_												
42299	UNLISTED PX PALATE UVULA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_												
42699	UNLISTED PX SALIVRY GLND/DUX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_												
42999	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.	-	-	- Add effective												
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	-	01/01/2023												
43291	EGD FLX TRNSORL RMVL 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 43499	EGD FLX TRNSORL RMVL BALO UNLISTED PROCEDURE ESOPHAGUS	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). Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	1/1/2023	-	-												
43499 43633			1/1/2023 _ _	-													
43499 43633 43644	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y	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.	1/1/2023 _ _ _	- - -													
43499 43633 43644 43645	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y LAP GASTR BYPASS INCL SMILL I	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023 _ _ _ _ _	-													
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43499 43633 43644 43645 43659 43770	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y LAP GASTRIC BYPASS INCL SMLL I UNLISTED LAPS PK STOMACH LAP PLACE GASTR ADJ DEVICE	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	1/1/2023 - - - - - - - -	-													
43499         43633           43644         43645           43659         43770	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y LAP GASTR BYPASS INCL SMLL I UNLISTED LAPS PX STOMACH LAP PLACE GASTR ADJ DEVICE LAP REVISE GASTR ADJ DEVICE	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 reviewed 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	1/1/2023 - - - - - - - -	- - - - -													
43499           43633           43644           43645           43659           43770           43771           43772	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y LAP GASTR BYPASS INCL SMIL I UNLISTED LAPS PX STOMACH LAP PLACE GASTR ADJ DEVICE LAP RRVISE GASTR ADJ DEVICE LAP RRVISE GASTR ADJ DEVICE	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. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	1/1/2023 - - - - - - - - - - - - -	-													
43499         43633           43644         43645           43659         43770	UNLISTED PROCEDURE ESOPHAGUS REMOVAL OF STOMACH PARTIAL LAP GASTRIC BYPASS/ROUX-EN-Y LAP GASTR BYPASS INCL SMLL I UNLISTED LAPS PX STOMACH LAP PLACE GASTR ADJ DEVICE LAP REVISE GASTR ADJ DEVICE	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. 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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	-	- - - - - - - - -	01/01/2023 - - - - - - - - - - - - -												
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)549	UNLISTED LAPS PX RENAL	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
)592	PERC RF ABLATE RENAL TUMOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
593	PERC CRYO ABLATE RENAL TUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
949	UNLISTED LAPS PX URETER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
715	ENDOSCOPIC INJECTION/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
999	UNLISTED LAPS PX BLADDER	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
327	CYSTOSCOPY INJECT MATERIAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
441	CYSTOURETHRO W/IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
442	CYSTOURETHRO W/ADDL IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
855	INSERT PROST URETHRAL STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
860	TRANSURETHRAL RF TREATMENT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
899	UNLISTED PX URINARY SYSTEM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
125	REMOVAL OF PENIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
200	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
205	TREATMENT OF PENIS LESION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
235	Penile Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
400	INSERT SEMI-RIGID PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
401	INSERT SELF-CONTD PROSTHESIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
105	INSERT MULTI-COMP PENIS PROS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
560	REVISION OF TESTIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
599	UNLISTED LAPS PX TESTIS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
559	UNLSTD LAPS PX SPRMATIC CORD	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
380	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.	-	_	_
199	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.	-	-	_
970	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.	-	-	_
980	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.	_	-	-
805	REPAIR CLITORIS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
10	REPAIR OF PERINEUM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
91	CONSTRUCTION OF VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
92	CONSTRUCT VAGINA WITH GRAFT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
35	REPAIR VAGINA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
26	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.	_	-	_
78	UNLISTED LAPS PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
79	UNLISTED HYSTSC PX UTERUS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-
579	UNLISTED LAPS PX OVIDCT OVRY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99	UNLISTED PX FML GENITAL SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
)74	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.	-	-	-
397	UNLISTED FETAL INVAS PX W/US	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
398	UNLSTD LAPS PX MAT CARE&DLVR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99	UNLISTED PX MAT CARE&DLVR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
59	UNLISTED LAPS PX ENDOC SYS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99	UNLISTED PX ENDOCRINE SYSTEM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
30	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).	-	-	-
i35	INTRACRAN ANGIOPLSTY W/STENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
50	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.	-	-	_
551	Evasc Pring Admn Rx Agnt Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
263	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).	_	_	_
264	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).	-	-	-
287	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).	-	-	-
582	OPN MPLTJ HPGLSL NSTM ARY PG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
528	TRML DSTRJ IOS BVN 1ST 2 L/S	contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to ore-service review. Check EIU policy. which is one of our Clinical Payment and Coding Policy (CPCP).			
529	TRML DSTRJ IOS BVN EA ADDL	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Codine Policy (CPCP).	-	_	_
540	INJECTION TREATMENT OF NERVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	_
99	UNLISTED PX NERVOUS SYSTEM	Unlisted Procedure: May require Prior Authorization per contract agreement.	-	-	-
60	REVISION OF CORNEA	Non Covered: Proceedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
70	REVISE CORNEA WITH IMPLANT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
185	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.	-	-	-
.74	TRI UMI DILAO O/E CAN W/O ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
75	TRLUML DIL AQ O/F CAN W/O'ST	MP Citeties - rocedure/service reviewed against Medicar Only Citeties Journit on recommended Clinical Review (redecterimination) to avoid post-service review.	-	-	-
79	AQUEOUS SHUNT EYE W/O GRAFT	MP Criteria: Procedurg/service reviewed against Medical Poly Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
80	AQUEOUS SHUNT EYE W/GRAFT	me unerse indecate/pervice reviews against metical for the submit for Recommended Linical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/pervice reviews against metical for Diry Criteria: Journal for Recommended Linical Review (Predetermination) to avoid post-service review.	-	-	-
.83	INSERT ANT DRAINAGE DEVICE	MP Citeties - rocedure/service reviewed against Medicar Oney Citeties Journit on recommended Clinical Review (redectermination) to avoid post-service review.	-	-	-
189	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.	-	-	-
91	XCAPSL CTRC RMVL INSJ 1+	MP Criteria: Proceeding/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	
99	UNLISTED PX ANT SEGMENT EYE	Unlisted: Procedure/Service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_
99	UNLISTED PX POSTERIOR SEGMNT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
99	UNLISTED PX EXTRAOCULAR MUSC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
99	UNLISTED PROCEDURE ORBIT	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
00	REPAIR BROW DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement.	-	-	-
01	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
02	REPAIR EYELID DEFECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
03	REPAIR EYELID DEFECT	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended clinical Review (Predetermination) to avoid post-service review.	-	-	-
04	REPAIR EYELID DEFECT	MP Criteria: Procedure/Jervice reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
06	REPAIR EYELID DEFECT	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended clinical Review (Predetermination) to avoid post-service review.	-	-	-
08	REPAIR EYELID DEFECT	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
99	UNLISTED PROCEDURE EYELIDS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
99	UNLISTED PX CONJUNCTIVA	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
99	UNLISTED PX LACRIMAL SYSTEM	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
90	PIERCE EARLOBES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Linical Review (Predetermination) to avoid post-service review.	-	-	-
00	REVISE EXTERNAL EAR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
99	UNLISTED PX EXTERNAL EAR	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
05	NPS SURG DILAT EUST TUBE UNI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
06	NPS SURG DILAT EUST TUBE BI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
14	Implant Temple Bone W/Stimul	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
	IMPL OI IMPLT SK TC ESP<100	Contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
16					
16		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			
	Temple Bone Implant Revision RPLCM OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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.	-	-	-

69730 69799	RPLC OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2023		Add effective
			1/1/2023	-	01/01/2023
69930	UNLISTED PX MIDDLE EAR Implant Cochlear Device	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 required p	er	-	-
69949		contract agreement.	-	-	-
69979	UNLISTED PX INNER EAR UNLISTED PX TEMPORAL BONE	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.	-	-	
76496	UNLISTED FLUOROSCOPIC PX	Unisted Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	
76497	UNLISTED CT PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
76498	UNLISTED MR PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_
76499	UNLISTED DX RADIOGRAPHIC PX	Unlisted: Procedure/Service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
76999 77299	ECHO EXAMINATION PROCEDURE UNLISTED PX THER RAD TX PLNG	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
77399	UNLISTED PX THER RAD TX PENG	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.	-	-	
77499	UNLISTED PX THER RAD TX MGMT	Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
77799	UNLISTED PX CLIN BRACHYTX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
78099	UNLISTED ENDOCRINE PX DX NUC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_
78199	UNLSTD HEMATOP RET/ENDO LYMP	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
78299 78399	UNLISTED GI PX DX NUC MED UNLISTED MUSCSKEL PX DX NUC	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.	-	-	-
78499	UNLISTED CV PX DX NUC MED	Unised: Procedure/service not specifically defined or classified, maybe subject to contract/unitial review.	-	-	-
78599	UNLISTED RESP PX DX NUC MED	Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			_
78699	UNLISTED NRVS SYS PX DX NUC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
78799	UNLISTED GU PX DX NUC MED	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
78999	UNLISTED MISC PX DX NUC MED	Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
79999 80299	RP THERAPY UNLISTED PX QUANTITATIVE ASSAY DRUG	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.	-	-	-
81099	UNLISTED URINALYSIS PX	Unised: 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	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	
82523	COLLAGEN CROSSLINKS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, 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 83698	ASSAY OF LIPOPROTEIN(A) 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).	-	-	-
83698	ASSAY LIPOPROTEIN PLA2 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). EIU: Procedure/service not 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	EUC: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUD 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	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).	-	-	-
84112 84431	EVAL AMNIOTIC FLUID PROTEIN 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). EIU: Procedure/service not 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		city. Traceouries in terminated by the rain too staglect to preserve reverse, tack sto painty, mining and count reinitiated by the rain too staglect to preserve reverse. Links sto painty, mining and count regiment and count protect (CPCP). Unlisted: Procedure/service not specifically defined or classified or to contract/finitial review.	-	-	-
85999	UNLISTED HEMATOLOGY&COAGJ PX	Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	_
86001	ALLERGEN SPECIFIC IGG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
86328	IA NFCT AB SARSCOV2 COVID19	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	_	Add effective 06/01/2023
86343	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.	-	-	_
86408	NEUTRLZG ANTB SARSCOV2 SCR	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	-	Add effective 06/01/2023
86409	NEUTRLZG ANTB SARSCOV2 TITER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	_	Add effective 06/01/2023
86413	SARS-COV-2 ANTB QUANTITATIVE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			Add effective
86486	SKIN TEST UNLISTED ANTIGN EA		6/1/2023		06/01/2023
86769			6/1/2023		
00703		Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_ Add effective
96940	SARS-COV-2 COVID-19 ANTIBODY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023 - 6/1/2023	-	Add effective 06/01/2023
86849 86910	IMMUNOLOGY PROCEDURE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	
86849 86910 86911		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	
86910	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY 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: 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.	-	- - - -	
86910 86911 86950 <mark>86999</mark>	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY TEST BLOOD TYPING ANTIGEN SYSTEM Leukacyte Transfusion UNLISTED TRANSFUSION MED 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). 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. Nor Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: 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.	-	- - - - - - - - -	
86910 86911 86950 86999 87505	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY TEST BLOOD TYPING ANTICER SYSTEM Leukacyte Transfusion UNLISTED TRANSFUSION MED PX NFCT AGENT DETECTION GI	EIU: Procedure/service not 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 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.         Mon Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.         Mn Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.         Unlisted: 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 (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.         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - - - - - -	
86910 86911 86950 86999 87505 87506	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY TEST BLOOD TYPING ANTIGEN SYSTEM Leukaryte Transfusion UNLISTED TRANSFUSION MED PX NFCT AGENT DETECTION GI IADNA-DNA/RNA PROBE TQ 6-11	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our. Clinical Payment and Coding Policy (CPCP).           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.           MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review.           MP Criteria: 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.           MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.           MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - - - - - - -	
86910 86911 86950 86999 87505	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY TEST BLOOD TYPING ANTICER SYSTEM Leukacyte Transfusion UNUSTED TRANSFUSION MED PX NFCT AGENT DETECTION GI	EIU: Procedure/service not 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 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.         Mon Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.         Mn Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.         Unlisted: 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 (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.         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	- - - - - - - - - - - - - - - - - -	
86910 86911 86950 86999 87505 87506 87506	IMMUNOLOGY PROCEDURE BLOOD TYPING PATERNITY TEST BLOOD TYPING ANTIGEN SYSTEM Leukacyte Transfusion UNLISTED TRANSFUSION MED PX NECT AGENT DETECTION GI IADNA-DNA/RNA PROBE TQ 12-25	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our. Clinical Payment and Coding Policy (CPCP).           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.           MC Totteria: Procedure/service not covered by the Plan. Not subject to pre-service review.           MC Totteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.           MC Totteria: 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.           MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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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89259	CRYOPRESERVATION SPERM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89335	CRYOPRESERVE TESTICULAR TISS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89337	CRYOPRESERVATION OOCYTE(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89342	STORAGE/YEAR EMBRYO(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89343	STORAGE/YEAR SPERM/SEMEN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89344	STORAGE/YEAR REPROD TISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
89346	STORAGE/YEAR OOCYTE(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
89398	UNLISTED REPROD MED LAB PROC	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_
90378	RSV MAB IM 50MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
90399	UNLISTED IMMUNE GLOBULIN	contract agreement. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
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90867	TCRANIAL MAGN STIM TX PLAN	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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90870	ELECTROCONVULSIVE THERAPY	nm checka zu procedune periode against weukar touk y checka submit für Recommendee Chicka Review (Predetermination) to avoid post-service review. MP Checka: Procedune/service reviewed against Weukar touk y Checka: Submit to Recommendee Chicka Review (Predetermination) to avoid post-service review.	-	-	-
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90878	PSYCHOPHYSIOLOGICAL THERAPY	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
90880	HYPNOTHERAPY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
90885	PSY EVALUATION OF RECORDS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	PREPARATION OF REPORT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
90899	UNLISTED PSYC SVC/THERAPY	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
90901	BIOFEEDBACK TRAIN ANY METH	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
90912	BFB TRAINING 1ST 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
90913	BFB TRAINING EA ADDL 15 MIN	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
90999	UNLISTED DIALYSIS PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
91034	Gastroesophageal Reflux Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
91035	G-Esoph Reflx Tst W/Electrod	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
91037	Esoph Imped Function Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
91038	Esoph Imped Funct Test > 1Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
91065	BREATH HYDROGEN/METHANE 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).	-	-	-
91110	GI TRC IMG INTRAL ESOPH-ILE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
91111	GI TRC IMG INTRAL ESOPHAGUS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
91112	GI WIRELESS CAPSULE 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).	-	-	-
91113	GI TRC IMG INTRAL COLON I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	_	Add effective 01/01/2023
91117	Colon Motility 6 Hr Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			01/01/2023
91132	ELECTROGASTROGRAPHY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
91133	ELECTROGASTROGRAPHY W/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).		-	-
91299	UNLISTED DX GI PROCEDURE	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		-
			4/18/2022	-	Add effective
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Non Covered: Procedure/Service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
91301	SARSCOV2 VAC 100MCG/0.5ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	_	Add effective 04/18/2023
91305					Add effective
91305	SARSCOV2 VAC 30 MCG TRS-SUCR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			04/18/2023
			4/18/2023	-	04/18/2025
91306	SARSCOV2 VAC 50MCG/0.25ML IM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective
	SARSCOV2 VAC 50MCG/0.25ML IM		4/18/2023	-	
91306 91307		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.	1 4 5 5	-	Add effective 04/18/2023 Add effective 04/18/2023
	SARSCOV2 VAC 50MCG/0.25ML IM		4/18/2023	- - -	Add effective 04/18/2023 Add effective 04/18/2023 Add effective
91307 91308	SARSCOV2 VAC 50MCG/0.25ML IM SARSCOV2 VAC 10 MCG TRS-SUCR SARSCOV2 VAC 3 MCG TRS-SUCR	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.	4/18/2023 4/18/2023 4/18/2023	- - -	Add effective 04/18/2023 Add effective 04/18/2023 Add effective 04/18/2023
91307	SARSCOV2 VAC 50MCG/0.25ML IM SARSCOV2 VAC 10 MCG TRS-SUCR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023 4/18/2023	- - - -	Add effective 04/18/2023 Add effective 04/18/2023 Add effective 04/18/2023 Add effective 04/18/2023
91307 91308	SARSCOV2 VAC 50MCG/0.25ML IM SARSCOV2 VAC 10 MCG TRS-SUCR SARSCOV2 VAC 3 MCG TRS-SUCR	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.	4/18/2023 4/18/2023 4/18/2023	- - - -	Add effective 04/18/2023 Add effective 04/18/2023 Add effective 04/18/2023 Add effective 04/18/2023 Add effective
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95199	UNLISTED ALL/IMMLG SVC/PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
95700	Eeg Cont Rec W/Vid Eeg Tech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95705	Eeg W/O Vid 2-12 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	
95706	Eeg Wo Vid 2-12Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95707	Eeg W/O Vid 2-12Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
95709	Eeg W/O Vid Ea 12-26Hr Intmt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
95710	Eeg W/O Vid Ea 12-26Hr Cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95711	Veeg 2-12 Hr Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95712	Veeg 2-12 Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95713	Veeg 2-12 Hr Cont Mntr		-	-	-
95713	Veeg Ea 12-26 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95715			-	-	-
	Veeg Ea 12-26Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95716	Veeg Ea 12-26Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95718	Eeg Phys/Qhp 2-12 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95719	Eeg Phys/Qhp Ea Incr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95720	Eeg Phy/Qhp Ea Incr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95721	Eeg Phy/Qhp>36<60 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95722	Eeg Phy/Qhp>36<60 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
95724	Eeg Phy/Qhp>60<84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95725	Eeg Phy/Qhp>84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95726	Eeg Phy/Qhp>84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95803	ACTIGRAPHY TESTING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95905	MOTOR &/ SENS NRVE CNDJ TEST	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).	-	-	-
			-	-	- Add effective
95919	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	-	01/01/2023
95954	Eeg Monitoring/Giving Drugs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
95957	Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
95965	MEG SPONTANEOUS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
95966	MEG EVOKED SINGLE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
95967	MEG EVOKED SACH ADDL	MP Criteria: Procedure/Service reviewed against Medical Delicy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
95999	UNLISTED NEUROLOGICAL DX PX	Wr Cittelia. Procedure/service rowewed against wiedlan routy Cittelia. Subinit for recommended Cinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
96000	MOTION ANALYSIS VIDEO/3D	Unisete: Procedure/service not specimicary derines or classifies, maybe subject to contract/clanical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96001	MOTION TEST W/FT PRESS MEAS		-	-	-
	DYNAMIC SUBFACE FMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96002		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96003	DYNAMIC FINE WIRE EMG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96004	PHYS REVIEW OF MOTION TESTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96379	UNL THER/PROP/DIAG INJ/INF	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
96549	UNLISTED CHEMOTHERAPY PX	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
96912	PHOTOCHEMOTHERAPY WITH UV-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96913	PHOTOCHEMOTHERAPY UV-A OR B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
96922	Laser Tx Skin >500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
96931	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
96932	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96933	Rcm Celuir Subceluir Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
96934	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
96935	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
96936	Rcm Celulr Subcelulr Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
		Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		-	-
96999	LINUISTED SPEC DERM SVC/PX				-
96999 97039	UNLISTED SPEC DERM SVC/PX		-	-	
97039	UNLISTED MODALITY	Unlisted Procedure; May require Prior Authorization per contract agreement.	-	_	_
97039 97139	UNLISTED MODALITY UNLISTED THERAPEUTIC PX	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
97039 97139 97169	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Non Covered: Procedure/Service not covered by the Plan. Not subject to pre-service review.		-	
97039 97139 97169 97170	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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.	- - - -	-	- - -
97039 97139 97169 97170 97171	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx Athletic Trn Eval Migh Cmplx	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Non Covered: Procedure;Nervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure;Nervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure;Nervice not covered by the Plan. Not subject to pre-service review.	-	- - - - -	- - - -
97039 97139 97169 97170 97171 97172	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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.	-	- - - - - - -	- - - - -
97039 97139 97169 97170 97171 97172 97533	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx Athletic Trn Eval High Cmplx Athletic Trn Re-Eval Plan Cr Sensory Integration	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - - -	- - - - - -
97039 97139 97169 97170 97171 97172 97533 97537	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Tm Eval Low Cmplx Athletic Tm Eval Mod Cmplx Athletic Tm Eval High Cmplx Athletic Tm Reval High Cmplx Athletic Tm Reval Plan Cr Sensory Integration Community/Work Reintegration	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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.	- - - -	- - - -	- - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537 97610	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx Athletic Trn Eval High Cmplx Athletic Trn Re-Eval Plan Cr Sensory Integration	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - -	- - - -	- - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Tm Eval Low Cmplx Athletic Tm Eval Mod Cmplx Athletic Tm Eval High Cmplx Athletic Tm Reval High Cmplx Athletic Tm Reval Plan Cr Sensory Integration Community/Work Reintegration	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted 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. Mon Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	- - - -	- - - -	- - - - - - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537 97610	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Tm Eval Low Cmpk Athletic Tm Eval Mod Cmplx Athletic Tm Seval High Cmplx Athletic Tm Re-Sval Plan Cr Sensory Integration Community,Work Reintegration LOW FREQUENCY NON-THERMAL US	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; Very envire Prior Authorization per contract agreement. 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. Mor Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EU: Procedure/service not relimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	- - - -	- - - -	- - - - - - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537 97610 97799	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx Athletic Trn Eval High Cmplx Athletic Trn Re-Eval Plan Cr Sensory Integration Community/Work Reintegration LOW FREQUENCY NON-THERNAL US UNLISTED PHYSCL MED/REHAB PX	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted 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. Nor Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. INP Criteria: Procedure/service not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - - -	- - - -	- - - - - - - - - - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537 97610 97799 99024	UNLISTED MODALITY UNLISTED THERAPEUTIC PX Athletic Trn Eval Low Cmpk Athletic Trn Eval High Cmpk Athletic Trn Eval High Cmpk Athletic Trn Sel High Cmpk Community/ Work Reintegration Low FREQUENCY NON-THERMAL US UNLISTED PHYSCL MED/REHAB PX Postop Follow-Up Visit	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. Not kiele for or Clinical Policy, CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical Review. Not Covered: 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. Non Covered: 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.	- - - -	- - - -	- - - - - - - - - - - - - - - - - - -
97039 97139 97169 97170 97171 97172 97533 97537 97610 97799 99024 99026	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Trn Eval Low Cmpix Athletic Trn Eval Mod Cmpix Athletic Trn Eval High Cmpix Athletic Trn Eval High Cmpix Athletic Trn Eval High Cmpix Community. Work Reintegration COW REQUENCY NON-THERNAL US UNLISTED PHYSCL MED/REHAB PX Postop Follow-Up Visit IN-HOSPITAL ON CALL SERVICE	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. Mon Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Mon Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Policy (CPCP). Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not specifically defined or classified, maybe subject to cortact/clinical review. Non Covered: Procedure/service not specifically defined or classified, maybe subject to cortact/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.	- - - -	- - - -	- - - - - - - - - - - - - - - - - - -
97039 97139 97169 97170 97170 97171 97533 97537 97610 97799 99024 99026 99027	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Tm Eval Low Cmpk Athletic Tm Eval Mod Cmpk Athletic Tm Seval Migh Cmpk Athletic Tm Seval Migh Cmpk Athletic Tm Re-Sval Plan Cr Sensory Integration Community, Work Reintegration LOW FREQUENCY NON-THERMAL US UNLISTED PHYSCL MED/REHAB PX Postop Follow-Up Visit IN HOSPITA ON CALL SERVICE OUT-OF-HOSP ON CALL SERVICE	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service not reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. EIU: Procedure/service not specifically defined or classified, maybe subject to cortact/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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - -	- - - -	
97039 97139 97169 97170 97171 97533 97537 97610 97799 99024 99026 99027 99050	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Trn Eval Low Cmplx Athletic Trn Eval Højh Cmplx Athletic Trn Re-I Mod Cmplx Athletic Trn Re-Eval Plan Cr Sensory Integration Community/Work Reintegration Low FREQUENCY NON-THERNAL US UNLISTED PHYSCL MED/REHAB PX Postop Follow-Up Visit IN-HOSPITAL ON CALL SERVICE OUT-OF-HOSP ON CALL SERVICE MEDICAL SERVICES ATER HRS	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not enhoursed by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not enhoursed by the Plan. Not subject to pre-service review. MP Criteria: 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. 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. Unlisted: Procedure/service not covered by the Plan. Not subje	- - - -	- - - -	-
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97039 97139 97159 97170 97171 97172 97172 97533 97537 97610 97739 9002 9002 9002 9005 9005 9005 9007 9	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic Trn Eval Low Cmpk Athletic Trn Eval Low Cmpk Athletic Trn Eval Mod Cmpk Athletic Trn Eval Mod Cmpk Athletic Trn Eval High Cmpk IOW FREQUENCY NON-THERMAL US UNLISTED PHYSICL MED/REHAB PX Postop Follow-Up Visit IN-HOSPITAL ON CALL SERVICE OUT-OF-HOSP ON CALL SERVICE OUT-OF-HOSP ON CALL SERVICE OFFICE EMERGENCY CARE SPECIAL SUPPLIES PHYS/QMP PATIENT EDUCATION MED/CAL TESTIMONY GROUP HEALTH EDUCATION SPECIAL REPORTS OR FORMS UNUSUAL REPORTS OR FORMS UNUSUAL PHYSICIAN TRAVEL Hyperbatic Dovgen Therapy UNLISTED SPECIAL SVC PK/RPT PHYSICIAN STANDBY SERVICES UNLISTED PREVENTIVE SERVICE Ntrprof Ph1/Ntmet/Ehr 3-10 Ntrprof Ph1/Ntmet/Ehr 3-10 Ntrprof Ph1/Ntmet/Ehr 3-10 Ntrprof Ph1/Ntmet/Ehr 3-17 BASIC LIFE DBALITY EXAM Ntrprof Ph1/Ntmet/Ehr 5/S Ntrprof Ph1/Ntmet/Ehr 3/S Rem Mint Physiol Param Setup Rem Mint Physiol Param Setup WORK RELATED DISABILITY EXAM	Unisted Procedure, May require Prior Authorization per contract agreement. Unised Procedure, May require Prior Authorization per contract agreement. Unised Procedure, May require Prior Authorization per contract agreement. Non Covered: Procedure/service not covered by the Plan. Not subject to per-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to per-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to per-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to per-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to per-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to per-service review. Check EUD Procedure/service not secured parts Madical Palo() Criteria. Submit for Recommedded Clinical Review (Predetermination) to avoid post service review. EUD: Procedure/service not secured parts Madical Palo() Criteria. Submit for Recommedded Clinical Review (Predetermination) to avoid post service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Unisted: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. Not subject to per-service review. Non Covered: Procedure/service not secured by the Plan. No	- - - - - - - - - - - - - - - - - - -		
97039 97139 97159 97170 97171 97172 97533 97610 97537 97610 90024 90024 90025 9005 90	UNLISTED MODALITY UNLISTED THERAFEUTIC PX Athletic The Eval Low Cmpk Athletic The Sell Mod Cmpk Community, Work Reintegration LOW FREQUENCY NON-THERMAL US UNLISTED PHYSICL MED/REHAB PX Postop Follow-Up Visit IN-HOSPTAL ON CALL SERVICE OUT-OF-HOSP ON CALL SERV	Unlisted Procedure; May require Prior Authorization per contract agreement. Unlisted Procedure; May require Prior Authorization per contract agreement. Non Covered: Procedure; New require Prior Authorization per contract agreement. Non Covered: Procedure; New require Prior Authorization per contract agreement. 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. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-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 seedifically edited or classified, mays subject to contract/clinical review. Non Covered: Procedure/service not seedifically defined or classified, mays subject to contract/clinical review. Non Covered: Procedure/service not seedifically defined or classified, mays subject to contract/clinical review. Non Covered: Procedure/service not seedifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not seedifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not seedifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, mays subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, mays subject to contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, mayse su	- - - - - - - - - - - - - - - - - - -		

99499 99600	UNLISTED E&M SERVICE UNLISTED HOME VISIT SVC/PX	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.	_	-	_
0745T	the second second	Uninsted. Procedure/service not specifically defined of classified, maybe souger to contract/clinical review.	6/15/2023	_	Add effective
0746T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	-	Add effective
)747T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	-	06/15/2023 Add effective
0748T				-	06/15/2023 Add effective
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023 Add effective
0765T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	-	06/15/2023
0770T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0771T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0772T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0773T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	_	Add effective 09/01/2023
0774T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	_	Add effective 09/01/2023
0776T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023		Add effective
0776T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	09/01/2023 Add effective 06/01/2023; Retire
				0,01,2020	effective 08/31/2023 Add effective
0777T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023 Add effective
0778T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023 Add effective
0779T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023
0781T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0782T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0782T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
A2020		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023		effective 08/31/2023 Add effective
				-	09/01/2023 Add effective
A2020		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
A2021		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective 04/18/2023
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective 04/18/2023
0003A	ADM SARSCOV2 30MCG/0.3ML 3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	_	Add effective
0004A	ADM SARSCOV2 30MCG/0.3ML BST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023		04/18/2023 Add effective
0011A	ADM SARSCOV2 100MCG/0.5ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
012A	ADM SARSCOV2 100MCG/0.5ML2ND		7.4.1.1	-	04/18/2023 Add effective
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
0013A	ADM SARSCOV2 100MCG/0.5ML3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
0051A	ADM SARSCV2 30MCG TRS-SUCR 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0052A	ADM SARSCV2 30MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective 04/18/2023
0052U	LPOPRTN BLD W/5 MAJ CLASSES	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_ Add effective
0053A	ADM SARSCV2 30MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
0054A	ADM SARSCV2 30MCG TRS-SUCR B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0054T 0055T	BONE SRGRY CMPTR FLUOR IMAGE BONE SRGRY CMPTR CT/MRI IMAG	EIU: Procedure/service not 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).	-	-	-
D062U	AI SLE IGG&IGM ALYS 80 BMRK	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
063U	NEURO AUTISM 32 AMINES ALG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	 Add effective
0064A	ADM SARSCOV2 50MCG/0.25MLBST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0066U	PAMG-1 IA CERVICO-VAG FLUID	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	 Add effective
0071A	ADM SARSCV2 10MCG TRS-SUCR 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
0072A	ADM SARSCV2 10MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0073A	ADM SARSCV2 10MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective 04/18/2023
0074A	ADM SARSCV2 10MCG TRS-SUCR B	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	Add effective 04/18/2023
0075T	PERQ STENT/CHEST VERT ART	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0076T	S&I STENT/CHEST VERT ART ADM SARSCV2 3MCG TRS-SUCR 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- 4/18/2023	-	Add effective
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	04/18/2023 Add effective
0082A	ADM SARSCV2 3MCG TRS-SUCR 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023 Add effective
A5800	ADM SARSCV2 3MCG TRS-SUCR 3	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0084U 0086U	Rbc Dna Gnotyp 10 Bld Groups Nfct Ds Bact&Fng Org Id 6+	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.	-	-	-
0087U	Crd Hrt Trnspl Mrna 1283 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	_	_	-
088U	Trnsplj Kdn Algrft Rej 1494	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0000		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
	Onc MInma Prame & Linc00518 Onc Cutan MInma Mrna 23 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.			Add effective
090U		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	_	
0090U 0091A	Onc Cutan Minma Mrna 23 Gene		- 4/18/2023 -	-	04/18/2023
0089U 0090U 0091A 0091U 0092A	Onc Cutan Minma Mrna 23 Gene ADM SARSCOV2 50 MCG/.5 ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023 4/18/2023	-	
0090U 0091A 0091U 0092A	Onc Cutan Minma Mrma 23 Gene ADM SARSCOV2 50 MCG/.5 ML1ST Onc Circt Scr Whi Bid Alg	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.	-	-	04/18/2023 - Add effective 04/18/2023 -
0090U 0091A 0091U	Onc Cutan Minma Mrna 23 Gene ADM SARSCOV2 50 MCG/.5 ML1ST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/.5 ML2ND	Nan 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.	-	- - -	04/18/2023 - Add effective
0090U 0091A 0091U 0092A 0092U 0093A	Onc Cutan Minma Mma 23 Gene ADM SARSCOV2 50 MCG/-5 MLIST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/-5 ML2ND Onc Lng 3 Prtn Bmrk Pism Alg	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.	- 4/18/2023 -	- - - -	04/18/2023 - Add effective 04/18/2023 - Add effective 04/18/2023 -
0090U 0091A 0091U 0092A 0092U 0093A 0093U	Onc Cutan Minma Mma 23 Gene ADM SARSCOV2 50 MCG/.5 MLIST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/.5 ML2ND Onc Lng 3 Prtn Bmrk Pism Alg ADM SARSCOV2 50 MCG/.5 ML3RD Rx Mntr 65 Com Drugs Urine ADM SARSCOV2 50 MCG/.5 MLBST	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.	- 4/18/2023 -	-	04/18/2023 - Add effective 04/18/2023 - Add effective
0090U 0091A 0091U 0092A 0092U 0093A 0093U 0094A	Onc Cutan Minma Mma 23 Gene ADM SARSCOV2 50 MCG/.5 ML1ST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/.5 ML2ND Onc Lng 3 Prtn Bmrk Pism Alg ADM SARSCOV2 50 MCG/.5 ML3RD Rx Mntr 65 Com Drugs Urine ADM SARSCOV2 50 MCG/.5 MLBST Genome Rapid Sequence Alys	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.	- 4/18/2023 - 4/18/2023 -	- - - - - - -	04/18/2023 - Add effective 04/18/2023 - Add effective 04/18/2023 - Add effective
0090U 0091A 0091U 0092A 0092U 0093A 0093U	Onc Cutan Minma Mma 23 Gene ADM SARSCOV2 50 MCG/.5 MLIST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/.5 ML2ND Onc Lng 3 Prtn Bmrk Pism Alg ADM SARSCOV2 50 MCG/.5 ML3RD Rx Mntr 65 Com Drugs Urine ADM SARSCOV2 50 MCG/.5 MLBST	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.	- 4/18/2023 - 4/18/2023 -	- - - - - - - - - - -	04/18/2023 - Add effective 04/18/2023 - Add effective 04/18/2023 - Add effective
0090U 0091A 0091U 0092A 0092U 0093A 0093U 0094A 0094U 0095U	Onc Cutan Minma Mma 23 Gene ADM SARSCOV2 50 MCG/.5 MLIST Onc Circt Scr Whi Bid Alg ADM SARSCOV2 50 MCG/.5 ML2ND Onc Ing 3 Prtn Bmrk Pism Alg ADM SARSCOV2 50 MCG/.5 ML3RD Rx Mntr 65 Com Drugs Urine ADM SARSCOV2 50 MCG/.5 ML8ST Genome Rapid Sequence Alys Infin Ee Elisa Alys Alg	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.	- 4/18/2023 - 4/18/2023 -	- - - - - - - - - - - - -	04/18/2023 - Add effective 04/18/2023 - Add effective 04/18/2023 - Add effective

0102T	ESW PHY ANES LAT HMRL EPCNDL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0102U	Hered Brst Ca Ritd Do 17 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	
0103U	Hered Ova Ca Pnl 24 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	
0105U	Neph Ckd Mult Eclia Tum Nec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
0106T	TOUCH QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
0106U	GSTR EMPTG 7 TIMED BRTH SPEC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
0107T	VIBRATE QUANT SENSORY TEST	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).	_	_	_
0107U	C Diff Tox Ag Detcj la Stool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
0108T	COOL QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
0108U	Gi Barrett Esoph 9 Prtn Bmrk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
0109T	HEAT QUANT SENSORY TEST	Tell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
			-	-	-
0109U	Id Aspergillus Dna 4 Species	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0110T	NOS QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0111A	ADM SARSCOV2 25MCG/0.25ML1ST	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	_	Add effective 04/18/2023
0111U	Onc Colon Ca Kras&Nras Alvs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.			04/16/2025
			_	-	Add effective
0112A	ADM SARSCOV2 25MCG/0.25ML2ND	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023	-	04/18/2023
0112U	ladi 165&185 Rrna Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0113A	ADM SARSCOV2 25MCG/0.25ML3RD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/18/2023		Add effective
			.,,	-	04/18/2023
0113U	Onc Prst8 Pca3&Tmprss2-Erg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0114U	Gi Barretts Esoph Vim&Ccna1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0115U	Respir ladna 18 Viral&2 Bact	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
0116U	Rx Mntr Nzm Ia 35+Oral Flu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
0117U	Pain Mgmt 11 Endogenous Anal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
D118U	Trnsplj Don-Drv Cll-Fr Dna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0119U	Crd Ceramides Lig Chrom Plsm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
01200	Onc B CILLymphm Mrna 58 Gen	Non Covered: Froedure/service not covered by the Plan. Not subject to preservice review. Prior Authorization may be required per contract aerement.	-	-	-
01200	Sc Dis Vcam-1 Whole Blood	· · · · · · · · · · · · · · · · · · ·	-	-	-
		Non Covered: Procedurg/service not covered by the Plan. Not subject to pre-service review.	-	-	-
01220	Sc Dis P-Selectin Whl Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0123U	Mchnl Fragility Rbc Prflg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
D129U	Hered Brst Ca Ritd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0130U	Hered Colon Ca Do Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	_	-	-
01310	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.	_	-	-
			-	-	-
01350	Hered Gyn Ca Mrna Pnl 12 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0136U	Atm Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0137U	Palb2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
0138U	Brca1 Brca2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	_	_	_
0140U	Nfct Ds Fungi Dna 15 Trgt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
0141U	Nfct Ds Bact&Fng Gram Pos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0142U	Nfct Ds Bact&Fng Gram Neg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0143U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
0144U	Drug Assay 160+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	-
01440			-	-	-
	Drug Assay 65+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0146U	Drug Assay 80+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0147U	Drug Assay 85+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0148U	Drug Assay 100+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
0149U	Drug Assay 60+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
0150U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
0152U	Nfct Ds Dna Untrgt Ngnrj Seq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
0153U	Onc Breast Mrna 101 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	_	_	_
0154U	Onc Urthl Ca Rna Fgfr3 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.			
01550	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.	-	-	-
01560	Copy Number Sequence Alvs	Non Covered: Procedure/Service not covered by the Plan. Not subject to pre-service review. Prior Authorization may be required per contract agreement.	-	-	-
01560			-	-	-
	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.	-	-	-
D161U	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.	-	-	-
D162U	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	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).			
0219T	PLMT POST FACET IMPLT CERV	EU: Proceeding-Service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP).	-	-	-
0220T	PLMT POST FACET IMPLT THOR	EUP roceause years on temporary of the rank not subject to pre-service review. Check EUP polycy, which is one of our Clinical Payment and Coding Toky (CPCP).	-	-	-
02201 0221T			-	-	-
	DI MT DOST EACET INADI TILINAD	EUL: Procedure/control not computed by the Disp. Not subject to proceeding check EUL value, which is one of our Click-Library and the two of the Disp.			-
	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).	-	-	
	PLMT POST FACET IMPLT LUMB 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). EIU: Procedure/service not 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			- 6/1/2023	-	Add effective
0222T 0224U	PLMT POST FACET IMPLT ADDL ANTIBODY SARS-COV-2 TITER(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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	Add effective 06/01/2023 Add effective
0222T 0224U 0226U	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).	_ 6/1/2023 6/1/2023	-	06/01/2023
0222T 0224U 0226U 0232T	PLMT POST FACET IMPLT ADDL ANTIBODY SARS-COV-2 TITER(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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		- - -	06/01/2023 Add effective
1222T 1224U 1226U 1232T	PLMT POST FACET IMPLT ADDL ANTIBODY SARS-COV-2 TITER(5) SVNT SARSCOV2 ELISA PLSM SRM	EIU: Procedure/service not 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).		- - -	06/01/2023 Add effective
0222T 0224U 0226U 0232T 0253T	PLMT POST FACET IMPLT ADDL ANTIBODY SARS-COV-2 TITER(S) SVNT SARSCOV2 ELISA PLSM SRM 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). EIU: Procedure/service not 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).		- - - -	06/01/2023 Add effective
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0331T	HEART SYMP IMAGE PLNR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0335T	INSJ SINUS TARSI IMPLANT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0338T	TRNSCTH RENAL SYMP DENRV UNL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0339T	TRNSCTH RENAL SYMP DENRV BIL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
0345T	TRANSCATH MTRAL VLVE REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
0347T	INS BONE DEVICE FOR RSA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0348T	RSA SPINE EXAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0349T	RSA UPPER EXTR EXAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	-
0350T	RSA LOWER EXTR EXAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	-
0352T	OCT BRST/NODE I&R PER SPEC	MP criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
				-	-
0354T	OCT BREAST SURG CAVITY I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0358T	BIA WHOLE BODY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
0378T	VISUAL FIELD ASSMNT REV/RPRT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0379T	VIS FIELD ASSMNT TECH SUPPT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0397T	ERCP W/OPTICAL ENDOMICROSCPY	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
0398T	MRGFUS STRTCTC LES ABLTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
0424T	INSJ/RPLC NSTIM APNEA COMPL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0425T	INSJ/RPLC NSTIM APNEA SEN LD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	-
0426T	INSJ/RPLC NSTIM APNEA STM LD	EIU: Procedure/service not 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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0427T	INSJ/RPLC NSTIM APNEA PLS GN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
0428T	RMVL NSTIM APNEA PLS GEN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
0429T	RMVL NSTIM APNEA SEN LD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
0430T	RMVL NSTIM APNEA STIMJ LD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0431T	RMVL/RPLC NSTIM APNEA PLS GN	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0432T	REPOS NSTIM APNEA STIMJ LD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
0433T	REPOS NSTIM APNEA SENSING LD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
0434T	INTERRO EVAL NPGS APNEA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	
0434T	PRGRMG EVAL NPGS APNEA	EIC: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIC policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
04351 0436T	PRGRMG EVAL NPGS APNEA 1 SES PRGRMG EVAL NPGS APNEA STUDY		-	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0449T	INSJ AQUEOUS DRAIN DEV 1ST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0450T	INSJ AQUEOUS DRAIN DEV EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0464T	VISUAL EP TEST FOR GLAUCOMA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
0465T	SUPCHRDL NJX RX W/O SUPPLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	_
0472T	PRGRMG IO RTA ELTRD RA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	_
0473T	REPRGRMG IO RTA ELTRD RA	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
0474T	INSJ AQUEOUS DRG DEV IO RSVR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
0479T	FXIL ABL LSR 1ST 100 SQ CM	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
0480T	FXJL ABL LSR EA ADDL 100SQCM	MP criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
04801 0483T				-	-
	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.		-	-
0485T	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).	_	-	-
0486T	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).	_	-	-
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).		-	_
0603T	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 CALBRJ 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).	_		
0620T	EVASC VEN ARTLZ TIBL/PRNL 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).	-	-	-
06201 0621T	TRABECULOSTOMY 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).	-	-	-
	TRABECULOSTOMY INTERNO LASER TRABECULOSTOMY INT LSR W/SCP		-	-	-
0622T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
0623T	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).	_	-	-
0624T	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).	_		
	PERQ 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).		-	-
0630T		EIU: Procedure/service not 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).	-	-	-
			-	-	– Retire effective
0631T	TC VIS LIT HYPERSPECTRAL IMG				06/30/2023
0631T		EIG: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIG pointy, 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).	-	6/30/2023	
0631T 0632T	TC VIS LIT HYPERSPECTRAL IMG		-	6/30/2023	-
0631T 0632T 0639T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTJ NRV P-ART 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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	6/30/2023	-
0631T 0632T 0639T 0640T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTJ NRV P-ART WRLS SKN SNR ANISOTROPY MEAS 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). EIU: Procedure/service not 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).	-	6/30/2023 - -	-
0631T 0632T 0639T 0640T 0641T	TC VIS LIT HYPERSPECTRAL IMG PERQ, TCAT US ABLTJ NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG	EUJ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EUJ: Procedure/service not 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).	-	6/30/2023 - - -	-
0631T 0632T 0639T 0640T 0641T 0642T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTI NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG NCNTC NR IFR SPCTRSC WND IÅR	EUU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EUU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EUU: Procedure/service not 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).	- - - - -	6/30/2023 - - - -	- - -
0631T 0632T 0639T 0640T 0641T 0642T 0643T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTI NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG NCNTC NR IFR SPCTRSC WND IAR TCAT L VENTR RSTRI DEV 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). EIU: Procedure/service not 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). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - -	6/30/2023 - - - - - -	- - - -
0631T 0632T 0639T 0640T 0641T 0642T 0643T 0645T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTJ NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPETRSC WND NCNTC NR IFR SPETRSC WND IMG NCNTC NR IFR SPETRSC WND I&R TCAT L VENTR RSTRI DEV IMPLT TCAT IMPLTJ C SINS RDCTJ DEV	EIU: Procedure/service not 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 reviewed against. Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against. Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		6/30/2023 - - - - - - - - -	- - - - -
0631T 0632T 0639T 0640T 0641T 0642T 0643T 0645T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTI NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG NCNTC NR IFR SPCTRSC WND IAR TCAT L VENTR RSTRI DEV 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). EIU: Procedure/service not 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). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - - - - - -	6/30/2023 	
0631T 0632T 0639T 0640T 0641T 0642T 0643T 0645T 0646T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTJ NRV P-ART WRLS SKN SNR ANISOTROPY MEAS NCNTC NR IFR SPETRSC WND NCNTC NR IFR SPETRSC WND IMG NCNTC NR IFR SPETRSC WND I&R TCAT L VENTR RSTRI DEV IMPLT TCAT IMPLTJ C SINS RDCTJ DEV	EIU: Procedure/service not 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 reviewed against. Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against. Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - - - - - -	6/30/2023 - - - - - - - - - - -	- - - - - - - - - - - - - - -
0630T 0631T 0632T 0640T 0640T 0641T 0642T 0643T 0645T 0646T 0650T 0651T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTI NRV P-ART WRLS SKN SNR ANISOTROPY MAAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG NCNTC NR IFR SPCTRSC WND I&R TCAT I VENTR RSTRI DEV IMPLT TCAT IMPLTJ C SINS RDCTJ DEV TTV/RPICMT W/PRSTC VLV PERQ PRGRMG DEV EVAL SCRMS REMOTE	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). EIU: Procedure/service not 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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	- - - - - - - - - - - - - - - - - - -	6/30/2023 - - - - - - - - - - -	- - - - - - Add effective
0631T 0632T 0639T 0640T 0640T 0641T 0642T 0643T 0645T 0645T 0650T 0651T	TC VIS LIT HYPERSPECTRAL IMG PERQ TCAT US ABLTJ NRV P-ART WRLS SKN SNR ANISOTROPY MAAS NCNTC NR IFR SPCTRSC WND NCNTC NR IFR SPCTRSC WND IMG NCNTC NR IFR SPCTRSC WND IÅR TCAT I LVENTR RSTRJ DEV IMPLIT TCAT IMPLIT S INS RDCTJ DEV TTV/RPLCMT W/PRSTC VLV PERQ PRGRMG DEV EVAL SCRMS REMOTE MAG CTRLD CAPSULE ENDOSCOPY	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). EIU: Procedure/service not 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). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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).	- - - - - - - - - - - - - - - - - - -	6/30/2023 - - - - - - - - - - - - -	- - - - - -
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0658T     Elec Impd Spectrx 1-Skn Les     MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.       0664T     DON HYSTERECTOMY OPEN CDVR     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0666T     DON HYSTERECTOMY CDFN LUV     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0666T     DON HYSTERECTOMY RCP UTR     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0666T     BKBENCH PRNST DON UTER ALGRFT     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0667T     BKBENCH RNST DON UTER ARTL     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0670T     BKBENCH RNST DON UTER ARTL     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0743T     B1ST & FX RSK VRT FX ASSMT     EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).       0744T     <	- - - - - - - - 1/1/2023 9/1/2023 9/1/2023 6/1/2023	- - - - - - - - - - - - - - - - - - -	
0665T       DON HYSTERECTOMY OPEN LIV       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0666T       DON HYSTERECTOMY LAPS UV       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0666T       DON HYSTERECTOMY RCP UTER       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0666T       BKERCH REND TO UTER ALGRET       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0669T       BKERCH REND TO UTER ALGRET       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0667T       BKERCH REND TO UTER ALGRET       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0677       BKERCH REND TISS       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0743T       B1 ST & FX RSK VRT FX ASSMT       EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical P	9/1/2023 6/1/2023 9/1/2023	- - - - - - - - - 8/31/2023	01/01/2023 Add effective 09/01/2023
D666T         DON HYSTERECTOMY LAPS UV         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           0666T         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).           0666T         BK8ENCH PREP DON UTER RAGRFT         EIU: Procedure/service not 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         BK8ENCH RCNSTD DON UTER ARTI         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           0677T         BK8ENCH RCNSTD DON UTER ARTI         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           06721         NDOVAG CRYG RF REMOL TSS         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           07431         B 1ST & K RS KW TF X 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).           0744T         MP Criteria: Procedure/service reviewed against Medicial Policy Criteria. Submit for Recommended Clinical Rev	9/1/2023 6/1/2023 9/1/2023	- - - - - - - - 8/31/2023	01/01/2023 Add effective 09/01/2023
6668T       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).         6668T       BKBENCH RENSTI 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).         6670T       BKBENCH RENSTI 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).         0744T       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0744T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NLX STM CL PRDCT ANL SFT TIS       EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	9/1/2023 6/1/2023 9/1/2023	- - - - - - 8/31/2023	01/01/2023 Add effective 09/01/2023
06697       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).         06707       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).         06727       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).         07437       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).         07447       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         07487       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).         07487       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).         07487       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).         07487       MP Criteria: Procedure	9/1/2023 6/1/2023 9/1/2023	- - - - - 8/31/2023	01/01/2023 Add effective 09/01/2023
06707         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).           06727         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).           07437         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).           07441         EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).           07447         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).           07448         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).           07487         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).           07487         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).           07647         MP Criteria: Procedure/se	9/1/2023 6/1/2023 9/1/2023	- - - - 8/31/2023	01/01/2023 Add effective 09/01/2023
0672T       NDOVAG CRYG RF REMDL TISS       EUL Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUL policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0743T       B1 STR & FX RSK VRT FX ASSMT       EUL Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUL policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0744T       EUL Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0744T       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NIX STM CL PRDCT ANL SFT TIS       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NIX STM CL PRDCT ANL SFT TIS       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0764T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       EUL Procedure/service review	9/1/2023 6/1/2023 9/1/2023	- - - 8/31/2023	01/01/2023 Add effective 09/01/2023
0743T       B1 STR & EX RSK VRT EX 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).         0744T       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0744T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NIX STM CL PRDCT ANL SET TIS         EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NIX STM CL PRDCT ANL SET TIS         EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0764T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EIU: Procedure/service	9/1/2023 6/1/2023 9/1/2023	- - 8/31/2023	01/01/2023 Add effective 09/01/2023
0744T       EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUI policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0744T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NX STM CL PRDCT ANL SFT TIS       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       NX STM CL PRDCT ANL SFT TIS       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0748T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0764T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0764T       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit f	9/1/2023 6/1/2023 9/1/2023	- 8/31/2023	Add effective 09/01/2023
07441       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07487       NIX STM CL PRDCT ANL SFT TIS       EUL Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPCP):         07487       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07487       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07647       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07657       Tc Mag Stimj Pn 151 Tx 1Nrv       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07657       Tc Mag Stimj Pn 151 Tx 1Nrv       EUL Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         076617       Tc Mag Stimj Pn 151 Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023 9/1/2023	- 8/31/2023	
0748T       NX STM CL PROCT ANL SFT TIS       EUC Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0748T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0764T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EUC Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EUC Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	9/1/2023	8/31/2023	Add effective
07481       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07647       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			06/01/2023; Retire
07481       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07647       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         07667       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			effective 08/31/2023 Add effective
0764T       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EIU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	-	09/01/2023 Add effective
0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0766T       Tc Mag Stimj Pn 1St Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		8/31/2023	06/01/2023; Retire effective 08/31/2023
0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).         0766T       Tc Mag Stimj Pn 15t Tx 1Nrv       MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023		Add effective
0766T         Tc Mag Stimj Pn 15t Tx 1Nrv         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	06/15/2023 Add effective
	7/1/2023	-	07/01/2023 Add effective
07677         Tc Mag Stimj Pn 1St Tx 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).	6/15/2023	6/30/2023	06/15/2023 and retire
It mag still pri ist is ta elo. Procedure/service not reinhoursed by the Plan. Not subject to pre-service review. Check Elo poincy, which is one of our Clinical Payment and Cooling Poincy (CPCP).	7/1/2023		effective 06/30/2023 Add effective
	//1/2023	-	07/01/2023 Add effective
07677 To Kag Stimj Pn 15t Tx Ea MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	06/15/2023 and retire
0768T Tc Mag Stimj Pn Sbsg Tx 1Nrv EIU: Procedure/service not 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		effective 06/30/2023 Add effective
	1/1/2025	-	07/01/2023 Add effective
07687 Tc Mag Stimj Pn Sbsq Tx 1Nrv MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	06/15/2023 and retire effective 06/30/2023
7657 Tc Mag Stimj Pn Sbsq Tx 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).	7/1/2023		Add effective
	.,.,	-	07/01/2023 Add effective
07691 Tc Mag Stimj Pn Sbsq Tx Ea MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/15/2023	6/30/2023	06/15/2023 and retire effective 06/30/2023
7707 VR TECHNOLOGY ASSIST THERAPY EU-Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023		Add effective
		-	09/01/2023 Add effective
0770T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
07711 VR PX DISSOC SVC SM PHY 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).	9/1/2023	_	Add effective 09/01/2023
			Add effective
0771T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
07721 VR PX DISSOC SVC SM PHY 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):	9/1/2023	_	Add effective 09/01/2023
			Add effective
0772T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
0773T VR PX DISSOC SVC OTH PHY 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).	9/1/2023	_	Add effective 09/01/2023
0773T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
			effective 08/31/2023
0774T VR PX DISSOC SVC OTH PHY 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).	9/1/2023	-	Add effective 09/01/2023
0774T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023: Retire
			effective 08/31/2023 Add effective
07757 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	-	01/01/2023
0776T THER INDCT J NTRABRN HYPTHRM EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
87777 R-T PRS SENSING EDRL GDN 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).	9/1/2023	_	Add effective 09/01/2023
			Add effective
0777T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
07787 SMMG CNCRNT APPL IMU SNR EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	_	Add effective 09/01/2023
0778T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
In criticial review expansion review against meanarraincy criteria, sauniti fui neculimiendo climical newew (redeterimination) to avoid post-service review.	0/1/2023	5/31/2023	effective 08/31/2023
07791 GI MYÖELECTRICAL ACTV STUDY 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).	9/1/2023	-	Add effective 09/01/2023
0779T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
			effective 08/31/2023 Add effective
0781T BRNCHSC RF DSTRJ PULM NRV 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).	9/1/2023	-	09/01/2023
0781T MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
			effective 08/31/2023 Add effective
07827 BRNCHSC RF DSTRI PLM NRV UNI EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023
0783T TC AURICULR NEUROSTIMULATION EUI: Procedure/service not 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
0791T Motor-cognitive, semi-immersive virtual EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPCP), reality-facilitated gain training, each 15 minute (List	7/1/2023	-	Add effective 07/01/2023
separately in addition to code for primary procedure)	7 /4 /3		Add effective
innervating the pulmonary arteries, including right heart	7/1/2023	-	Add effective 07/01/2023
catheterization, pulmonary artery angiography, and all imaging guidance			
making consider	7/1/2023	-	Add effective
			07/01/2023
leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography,			
leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device			
leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right strial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete strial and right			
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 (l.e., right atrial and right ventricular pacemaker components)			Add effective
leadless pacemaker, including imaging guidance (e.g.,         fluoroscopy, venous ultrasound, right atrial angiography,         influoroscopy, venous ultrasound, right atrial angiography,         evaluation (e.g., interrogation or programming), when         performed; complete system (i.e., right atrial and right         ventricular pacemaker components)         0796T       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	-	07/01/2023
leadless pacemaker, including imaging guidance (e.g.,         fluoroscopy, venous ultrasound, right atrial angiography,         ingit ventriculography, femoral venography) and device         evaluation (e.g., interrogation or programming), when         performed; complete system(i.e., right atrial and right         ventricular pacemaker components)         0796T       Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography,	7/1/2023	-	
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         ventricular pacemaker components)         0796T         ranscatheter insertion of permament dual-chamber         MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         right ventriculography, femoral venography), and device         evaluation (e.g., interrogation or programming), when	7/1/2023	-	
leadless pacemaker, including imaging guidance (e.g.,         fluoroscopy, venous ultrasound, right atrial angiography, femoral venography) and device         evaluation (e.g., interrogation or programming), when         performed; complete system (i.e., right atrial and right ventricular pacemaker components)         0796T       Transcathter insertion of permanent dual-chamber         NP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         fluoroscopy, venous ultrasound, right atrial angiography, right ventricular pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial and gorgaphy, right ventricular pacemaker component (when an end to the service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	
leadless pacemaker, including imaging guidance (e.g.,         fluoroscopy, venous ultrasound, right artial angiography,         ingit ventriculography, femoral venography) and device         evaluation (e.g., interrogation or programming), when         20796T       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.         evaluation (e.g., interrogation or programming), when	7/1/2023	-	

	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography right ventricularpahy, femoral venorgraphy) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of 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
0798T	system) Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	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
	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography, when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., flooroscopy, verous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of 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
0801T	system) Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg., fluoroscay, 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).	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
0802T	Transcatheter removal and replacement 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	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
0803T	nacemaker component Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscory, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	-	Add effective 07/01/2023
	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac	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
0805T	chambers. Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach	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
	valve implantation (i.e., caval valve implantation	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
0807T	[CAVI]): open femoral vein approach Pulmonary tissue ventilation analysis using software- based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, intercoretation and renord	EIU: Procedure/service not 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
	Pulmonary tissue ventilation analysis using software- based processing of data from separately captured cineflurograph 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,	EIU: Procedure/service not 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
0810T	interpretation 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
	Proc/Treat/Equip/Ins/Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	OTC Drugs Non-Covered Vision/Hear/Dental 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.	-	-	-
	Assit Disabled/Misc 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.		-	-
	Corr Eye Surgery Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
	Premiums Non- Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Copays Non-Covered Limited Purpose HCA 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.		-	-
	Preventative Care Non-Covered	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-
	Long Term Care Non-Covered NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Als 1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
A0430	Ambulance Service Conventional Air Services Transport One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	_
	Rotary wing air transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	-
	Fixed Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
	Rotary wing air mileage Noncovered ambulance mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
A0999	Unlisted ambulance service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	
	Innovamatrix ac 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).		_	-
	Mirragen adv wnd mat per sq Xcellistem 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
	Microlyte matrix per sq cm	EID. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EID 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 EID policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	
	Novosorb synpath 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).	-	-	-
	Restrata 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).	_	-	-
	Theragenesis per sq cm Symphony 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).		-	-
	Apis per square centimeter	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).	-	-	_
A2011	Supra sdrm 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).	_	_	-
	Suprathel 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).	-	-	-
A2013	Innovamatrix fs 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).	-	-	-

A2014	Omeza collag per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	-	Add effective 04/01/2023
A2014	Omeza collag per 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective
			-		03/31/2023 Add effective
A2015	Phoenix wnd mtrx per sq cm	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).	4/1/2023	-	04/01/2023
A2015	Phoenix wnd mtrx per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	3/31/2023	Retire effective 03/31/2023
A2016	Permeaderm b per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023		Add effective
A2016				-	04/01/2023 Retire effective
A2016	Permeaderm b per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	3/31/2023	03/31/2023
A2017	Permeaderm glove each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	-	Add effective 04/01/2023
A2017	Permeaderm glove each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/31/2023	Retire effective
			-		03/31/2023 Add effective
A2018	Permeaderm c 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).	4/1/2023	-	04/01/2023
A2018	Permeaderm c per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	3/31/2023	Retire effective 03/31/2023
A2019	Kerecis marigen shld sq cm	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).	9/1/2023	_	Add effective
					09/01/2023 Add effective
A2019	Kerecis marigen shld sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/15/2023	8/31/2023	05/15/2023; Retire
A2020	Art used and an		0/4/2022		effective 08/31/2023 Add effective
A2020	Ac5 wound 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).	9/1/2023	-	09/01/2023
A2021	Neomatrix 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).	9/1/2023	-	Add effective 09/01/2023
A2021			6/1/2023	8/31/2023	Add effective
A2021		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
A4100	Skin sub fda clrd as dev nos	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
A4335	Incontinence supply	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-
A4421	Ostomy supply misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-
A4458	Reusable enema bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
A4520	Incontinence garment anytype	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
A4553	Non-Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
A4554	Disposable underpads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
A4555 A4575	Ca tx e-stim electr/transduc Hyperbaric o2 chamber disps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	March 1 and 1 and 1 and 1	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	– Add effective
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	-	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.	_	-	-
A4890	Repair/maint cont hemo equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-
A4913	Misc dialysis supplies noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
A4927	Non-sterile gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
A4931	Reusable oral thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
A4932	Reusable rectal thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
A5507	Modification diabetic shoe	Unlisted: Procedure/service not specifically defined or classified, 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 A6262	Wound filler gel/paste /oz	Unisted: Procedure/Service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
A6262 A6512	Wound filler dry form / gram	Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
A6549	Compres burn garment noc G compression stocking	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.	-	-	-
			-	-	- Add effective
A7049	Epap nasal valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	09/01/2023
					Add effective 05/15/2023; Retire
A7049	Epap nasal valve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/15/2023	8/31/2023	
A7049			5/15/2023	8/31/2023	effective 08/31/2023
<b>A7049</b> A9150	Misc/exper non-prescript dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2023 -	8/31/2023	
A7049 A9150 A9152	Misc/exper non-prescript dru Single vitamin nos	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.	5/15/2023 _ _	8/31/2023 _ _	
A7049 A9150 A9152 A9153	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos	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.	5/15/2023 _ _ _	8/31/2023 _ _ _	
A7049 A9150 A9152 A9153 A9270	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service	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.	5/15/2023 - - - -	8/31/2023 - - -	
A7049 A9150 A9152 A9153 A9270 A9273	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos 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. 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.	5/15/2023 - - - - - -	8/31/2023 - - - -	
A7049 A9150 A9152 A9153 A9270	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service	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.	5/15/2023 - - - - - - - -	8/31/2023 	
A7049 A9150 A9152 A9153 A9270 A9273 A9279	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service Hot/cold botle/cap/col/wrap Monitoring feature/deviceNOC	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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	5/15/2023 	8/31/2023 	
A7049 A9150 A9152 A9153 A9270 A9273 A9279 A9280	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered Item or service Hot/cold botle/cap/col/wrap Monitoring feature/deviceNOC Alert device noc	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. Unlisted: Procedure/service not covered of classified, maybe subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	5/15/2023 	8/31/2023 	
A7049 A9150 A9152 A9153 A9270 A9273 A9279 A9280 A9282	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service Hot/cold botle/cap/c0/wrap Monitoring feature/deviceNOC Alert device noc Wig any type	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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: 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. 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.	5/15/2023 	8/31/2023 - - - - - - - - - - - - -	
A7049 A9150 A9152 A9153 A9270 A9273 A9279 A9280 A9282 A9285	Misc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service Hot/cold botie/cap/col/wap Monitoring feature/deviceNOC Alert device noc Wig any type Inversion eversion cor devic	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. 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. EIU: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2023 - - - - - - - - - - - - - - - - - - -	8/31/2023 - - - - - - - - - - - - -	
A7049 A9150 A9152 A9270 A9273 A9270 A9273 A9279 A9280 A9282 A9282 A9285 A9291 A9300 A9579	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Non-covered item or service Hot/cold botic/ap/col/wrap Monitoring feature/deviceNOC Alert device noc Wig any type Inversion eversion cor devic Pres dig cog behav thera fda	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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unlisted: Procedure/service not covered by the Plan. Not subject to contract/clinical review. EURISTED: Procedure/service not covered by the Plan. Not subject to contract/clinical review. EURISTED: Procedure/service not covered by the Plan. Not subject to contract/clinical review. EURISTED: Procedure/service not covered by the Plan. Not subject to contract/clinical review. EURISTED: Procedure/service not covered by the Plan. Not subject to contract/clinical review. EURISTED: 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. EURISTED: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/15/2023 	8/31/2023 - - - - - - - - - - - - -	
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A7049           A9150           A9152           A9153           A9270           A9273           A9273           A9274           A9282           A9282           A9283           A9291           A9300           A5598           A9598           A9598           A9598           A9599           A9598           A9990           A9990           C1761           C1764           C17763           C1825           C1825           C1825           C1825           C1825           C1825	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Multi-vitamin nos Hot/colid botle/cap/col/wrap Monitoring feature/deviceNOC Alett device noc Wig any type Inversion eversion cor devic Pres dig cog behav thera fda Exercise equipment Gad-base MR contrast NOS 1ml Pet dx for non-tumor id noc Pet dx for non-tumor id noc Non-rad contrast moto Simul Pet dx for non-tumor id noc Non-rad contrast moto Simul Supply/accessory/service DME supply or accessory nos Enteral supp not othrws e Parenteral supp not othrws e Hemostatic agent gi topic Cath trans intra litho/coro Event recorder cardiac Joint device (implantable) Ocular imp aqueous drain de Integrated keratoprosthesis Gen neuro trans son/stim Gen neuro card sinus baro Gen neuro card sinus baro	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. Unlisted: 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. Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, maybe subject to core-service review. But: Procedure/service not cerembursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: 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. 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. 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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical	- - - - - - - - - - - - - - - - - - -		effective 08/31/2023
A7049           A9150           A9152           A9153           A9270           A9273           A9273           A9273           A9273           A9273           A9273           A9273           A9282           A9282           A9283           A9291           A3300           A9598           A9598           A9598           A9598           A9598           A9999           C10761           C1764           C1783           C1823           C1826           C1827           C1827           C1823	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Multi-vitamin nos Mon-coveredi tem or service Hot/cold bote/cap/col/wrap Monitoring feature/deviceNOC Alert device noc Wig any type Inversion cor devic Pres dig cog behav thera fda Exercise equipment Gad-base MR contrast NOS 1ml Pet dx for non-tumor id noc Pet dx for non-tumor id noc Pet dx for non-tumor id noc Non-rad contrast materialNOC Radiopharm x agent noc Supply/accessory/service DME supply or accessory nos Enteral supp not othrws c Hermostatic agent git topic Cath trans intra litho/coro Event recorder cardiac Joint device (implantable) Occular ima gueusus drain de Integrated keratoprosthesis Gen neuro trans sen/stim Gen neuro tans sen/stim Gen neuro tans sen/stim Gen neuro tans sen/stim	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. Unitset: Procedure/service not covered by the Plan. Not subject to pre-service review. Unitset: 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 specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstef: Procedure/service not specifically defined or	- - - - - - - - - - - - - - - - - - -		effective 08/31/2023 
A7049           A71049           A9150           A9152           A9153           A9270           A9273           A9273           A9273           A9270           A9273           A9273           A9270           A9282           A9282           A9293           A9294           A9295           A9597           A9598           A9599           B9998           B9999           C1761           C1764           C1764           C1764           C1818           C1825           C1826           C1827           C1828           C1823           C1823           C1824           C1825           C1823           C1823           C1823	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Multi-vitamin nos Multi-vitamin nos Multi-vitamin nos Monitoring feature/deviceNOC Alett device noc Wig any type Inversion eversion cor devic Pres dig cog behav thera fda Exercise equipment Gad-base MR contrast NOS 1ml Pet dx for umor id noc Non-rad contrast materialNOC Radiopharm rx agent noc Supply/accessory/service DME supply or accessory nos Enteral supp not othrws c Hemostatic agent gi topic Cath trans intra litho/cor Event recorder cardiac Joint device (implantable) Ocular imp aqueous drain de Integrate keratoprosthesis Gen neuro trans sen/stim Gen neuro trans sen/stim	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 specifically defined or classified, maybe subject to contract/clinical review.           Unitstel: 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.           Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.           UNISted: Procedure/service not covered by the Plan. Not subject to pre-service review.           UNISted: Procedure/service not covered by the Plan. Not subject to pre-service review.           Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.           Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.           Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.           Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.           Unisted	- - - - - - - - - - - - - - - - - - -		effective 08/31/2023 
A7049           A9150           A9152           A9153           A9270           A9273           A9273           A9273           A9273           A9273           A9273           A9273           A9282           A9282           A9283           A9291           A3300           A9598           A9598           A9598           A9598           A9598           A9999           C10761           C1764           C1783           C1823           C1826           C1827           C1827           C1823	Nisc/exper non-prescript dru Single vitamin nos Multi-vitamin nos Multi-vitamin nos Mon-coveredi tem or service Hot/cold bote/cap/col/wrap Monitoring feature/deviceNOC Alert device noc Wig any type Inversion cor devic Pres dig cog behav thera fda Exercise equipment Gad-base MR contrast NOS 1ml Pet dx for non-tumor id noc Pet dx for non-tumor id noc Pet dx for non-tumor id noc Non-rad contrast materialNOC Radiopharm x agent noc Supply/accessory/service DME supply or accessory nos Enteral supp not othrws c Hermostatic agent git topic Cath trans intra litho/coro Event recorder cardiac Joint device (implantable) Occular ima gueusus drain de Integrated keratoprosthesis Gen neuro trans sen/stim Gen neuro tans sen/stim Gen neuro tans sen/stim Gen neuro tans sen/stim	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. Unitset: Procedure/service not covered by the Plan. Not subject to pre-service review. Unitset: 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 specifically defined or classified, maybe subject to contract/clinical review. Non Covered: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unitstet: Procedure/service not specifically defined or	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	effective 08/31/2023

C2699	Brachytx non-stranded NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
C5271	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
05272	Low cost skin substitute app		4/1/2023	-	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
0.0274	Low cost skin substitute app	MP Criteria: Procedure/service reviewed asainst Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2023	-	04/01/2023 Add effective
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	-	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
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	04/01/2023 Add effective
C5277	Low cost skin substitute app		4/1/2023	-	04/01/2023
C5278	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
		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			04/01/2023
C9257	Bevacizumab injection	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).	-	-	-
C9358	Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
C9338	square centimeters	EID. Procedure/service not reliminated by the Prain, not subject to pre-service review. Check Eid pointy, which is one of our clinical Payment and coung Pointy (CPCP).	-	-	-
C9360	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).	_	_	_
C9363	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).	_	-	-
C9364	Porcine implant Permacol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
C9399	unclassified drugs or biologicals	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
C9739	Cystoscopy prostatic imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
C9740	Cysto impl 4 or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
C9757	Spine/lumbar disk surgery	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9764	Revasc intravasc lithotripsy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	_
C9765	Revasc intra lithotrip-stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
C9766	Revasc intra lithotrip-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
C9767	Revasc lithotrip-stent-ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
C9768	Endo us-guide hep porto grad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	_
C9769	Cysto w/temp pros implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
C9770	Vitrec/mech pars subret inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
C9771	Nsl/sins cryo post nasal tis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
C9772	Revasc lithotrip tibi/perone	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
C9773	Revasc lithotr-stent tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
C9774	Revasc lithotr-ather tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
C9775	Revasc lith-sten-ath tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
C9777	Esophag muc integ w/eso egd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
C9898	Inpnt stay radiolabeled item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	_
C9899	Inpt implant pros dev no cov	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D0999	unspecified diagnostic procedure by report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
D1705	Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
	Dose 1 Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im		-	-	-
D1706	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.	_	-	_
D2999 D3410	unspecified restorative procedure by report apicoectomy - anterior	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.	-	-	_
			-	- - -	-
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - -	- - -	- - -
D3410 D3999 D4999	apicoectomy - anterior unspecified endodontic procedure by report	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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - - -	- - -	- - -
D3410 D3999 D4999 D5899	apicoectomy - anterior unspecified endodontic procedure by report unspecified periodontal procedure by report unspecified removable prosthodontic procedure by report	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. 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. 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.	- - - -	- - - -	- - - -
D3410 D3999 D4999 D5899 D5999	apicoectomy - anterior unspecified endodontic procedure by report unspecified periodontal procedure by report unspecified removable prosthodontic procedure by report unspecified maxillofacial prosthesis by report	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. 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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - - -	- - - -	- - - - -
D3410 D3999 D4999 D5899 D5899 D5999 D6199	apicoectomy - anterior unspecified endodontic procedure by report unspecified periodontal procedure by report unspecified removable prosthodontic procedure by report unspecified maxillofacial prosthesis by report unspecified implant procedure by report	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. 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. 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. 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.	- - - -	- - - - -	- - - - - -
D3410 D3999 D4999 D5899 D5999	apicoectomy - anterior unspecified endodontic procedure by report unspecified periodontal procedure by report unspecified removable prosthodontic procedure by report unspecified maxillofacial prosthesis by report unspecified implant procedure by report unspecified fixed prosthodontic procedure by report	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. 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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	- - - - - - -	- - - - - -
D3410 D3999 D4999 D5899 D5899 D5999 D6199	apicoectomy - anterior unspecified endodontic procedure by report unspecified removable prosthodontic procedure by report unspecified maxillofacial prosthesis by report unspecified implant procedure by report unspecified fixed prosthodontic procedure by report extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of	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. 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. 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. 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.	-	- - - - - - - - - - -	- - - - - - - -
D3410 D3999 D4999 D5899 D5999 D6199 D6999 D7210	apicoectomy - anterior unspecified endodontic procedure by report unspecified periodontal procedure by report unspecified removable prosthodontic procedure by report unspecified implant procedure by report unspecified implant procedure by report unspecified fixed prosthodontic procedure by report extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiotateal fiae if indicated	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. 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. 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. 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. 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.	-	- - - - - - - - - - -	- - - - - - - -
D3410 D3999 D4999 D5899 D6199 D6199 D6999 D7210 D7220	apicoectomy - anterior unspecified endodonic procedure by report unspecified removable prosthodonic procedure by report unspecified removable prosthodonic procedure by report unspecified maxillofacial prosthesis by report unspecified implant procedure by report unspecified implant procedure by report extraction erupted tooth requiring removal of borne end/or sectioning of tooth and including elevation of mucoperiosteal flam if indicated removal of impacted tooth - soft tissue	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. 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. 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. 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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unlisted: 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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0616	Cardiac event recorder	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	
0625	Patient lift bathroom or toi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-
0635	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.	_	_	-
637	Combination Sit To Stand Frame/Table System Any Size 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.			
057	Without Wheels	MP Criteria: Procedure/service reviewed against medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	Standing Frame/Table System One Position (E.G.				
538	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				
641	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		-	-	-
642	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.			_
	Stander) Any Size Including Pediatric				_
650	Pneuma compresor non-segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
651	Pneum compressor segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
652	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.	-	-	-
655	Pneumatic appliance half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
656	Segmental pneumatic trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
657	Segmental pneumatic chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
660	Pneumatic appliance full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
665	Pneumatic appliance full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
666					
	Pneumatic appliance half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
667	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.			-
668	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.		-	-
669	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.	-	-	_
670	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.	_	_	_
671	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.			
672	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.		_	
673	Pressure pneum appl half leg	We Oriteria: Procedure/service eviewed against metadar Joing Oriteria: Joanni for Recommended Efficial Review (Predetermination) to avoid post-service review.	-		-
675			-	-	-
		EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
576	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.	_	_	_
591	Uvl pnl 2 sq ft or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
692	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.	_	_	-
693	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.	_	_	-
694	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.			
740	Non-implant pely fir e-stim	EU: Proceeding/service not reliable blan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
740			-		-
	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.			-
760	Osteogen ultrasound stimItor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
0761	Nontherm electromgntc device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
762	Trans elec jt stim dev 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).	-	-	_
764	Functional neuromuscularstim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
766	Elec stim cancer treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
769	Electric wound treatment dev	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
770	Functional electric stim NOS		-	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
770	Functional electric stim NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
830	Ambulatory traction 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).	-	_	-
340	Tract frame attach headboard	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
849	Cervical pneum trac equip	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
0850	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).	_	_	_
0855	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).			
0856	Cervic collar w air bladders	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
0860			-	-	-
	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).	-	-	-
890	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).	-	-	-
936	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).	-	-	-
942	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).	_	-	-
944	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).	-	-	-
985	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.			
986	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.			
002	Pwr seat tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
					-
003	Pwr seat recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
004	Pwr seat recline mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
005	Pwr seat recline pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
006	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.	-	_	-
007	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.	_	-	-
008	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.	_	_	_
009	Add mech leg elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
010	Add meeting elevation Add pwr leg elevation	wir untern in Coccure/service reviewed against weckaft owy criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
			-	-	-
012	Ctr mount pwr elev leg rest	MP Citeria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
161	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.			_
229	Pediatric wheelchair NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		-	_
230	Power operated vehicle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
239	Ped power wheelchair NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
399	Durable medical equipment mi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	-
529	Tablo for dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
632	Wearable artificial kidney	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).			
599	Dialysis equipment noc	Los roccurregence not security and in the subject to presence entered to prince interest of prince interest and a competition of the prince interest of the prin	-	-	-
700	Jaw motion rehab system	· · · · · · · · · · · · · · · · · · ·	-	-	_
		EU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EUD policy, which is one of our Clinical Payment and Coding Policy (PCP).	-	-	-
01	Repl cushions for jaw motion	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
02	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).	-	-	-
00	Pwr seat elevation sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
01	Pwr standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
810	Electro connect btw control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
311	Electro connect btw control		-		
311		MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
	Mini-prop remote joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			-
813	PWC harness expand control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
321	Hand interface joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
22	Mult mech switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
323	Special joystick handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
324	Chin cup interface	wir chrefen in bezuger zwirke reinweite gannt weuten nur yn en en anne de men en e	-	-	
	cam cap interface		-	-	
	Cip and puff interfa				
25	Sip and puff interface Breath tube kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. 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.	_	_	_
	Head control nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	Head control proximity switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
			-	-	-
	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.	_	-	-
E2342	W/c dpth 20-21 in seat frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
	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.	-	-	-
	And a second second		-	-	-
	Electronic SGD interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2373	Hand/chin ctrl spec joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2374	Hand/chin ctrl std joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
E2375	Non-expandable controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	_
E2376	Expandable controller repl	MD Criteria: Procedure (envice reviewed aniset Medical Balicy Criteria: Submit for Recommended Clinical Review (Prodetermination) to avoid port-cension review	-	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	Expandable controller initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2500	SGD digitized pre-rec <=8min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2502	SGD prerec msg >8min <=20min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2504	SGD prerec msg>20min <=40min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			_
			-	-	-
	SGD prerec msg > 40 min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2508	SGD spelling phys contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2510	SGD w multi methods msg/accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
E2511	SGD sftwre prgrm for PC/PDA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
			-	-	-
	SGD accessory mounting sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2599	SGD accessory noc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
E2610	Wheelchair Seat Cushion Powered	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
G0176	OPPS/PHP;activity therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	Pet imaging any site not otherwise specified	Militade Procedure; May require Prior Authorization per contract agreement.	-	-	-
			-	-	-
	Current percep threshold tst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
G0276	Pild/placebo control clin tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement.	-	-	-
	Elec stim unattend for press	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	
G0282	Elect stim wound care not pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
G0293	Non-cov surg proc clin trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
			-	-	-
	Non-cov proc clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
	Electromagnetic therapy onc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
G0329	Electromagntic tx for ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
G0341	Percutaneous islet celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0342	Laparoscopy islet cell trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
			-	-	-
G0343	Laparotomy islet cell transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	Intensive Cardiac Rehabilitation; With Or Without	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
	Continuous Ecg Monitoring With Exercise Per Session Intensive Cardiac Rehabilitation: With Or Without				
	Continuous Ecg Monitoring; Without Exercise Per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
00425	Session		-	-	-
	Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
	Dermal Filler injection(s) for the treatment of facial				
G0429	linodystrophy syndrome (LDS) (e.g. as a result of highly	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
1.1.1			-	-	-
	active antiretroviral therapy.)		-	-	-
G0460	active antiretroviral therapy.) Autolog prp not diab ulcer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer	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). 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).	-	-	- -
G0460 G0465	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alcohol And/Or Substance (Other Than Tobacco) Misuse	EIU: Procedure/service not 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).	-	-	-
G0460 G0465	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief	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). 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).	-	- - -	-
G0460 G0465 G2011	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes	EIU: Procedure/service not 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). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	- - -
G0460 G0465 G2011 G2082	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes Visit esketamine 56m or less	EIU: Procedure/service not 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). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - -	- - -	-
G0460 G0465 G2011 G2082 G2083	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alchoil And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes Visit esketamine 56m or less Visit esketamine >56m	EIU: Procedure/service not 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). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	- - - -	-	- - -
G0460 G0465 G2011 G2082 G2083	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes Visit esketamine 56m or less	EIU: Procedure/service not 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). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
G0460 G0465 G2011 G2082 G2083 G8395	active antiretroviral therapy.) Autolog prp not diab ulcer Autolog prp diab wound ulcer Alchoil And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes Visit esketamine 56m or less Visit esketamine >56m	EIU: Procedure/service not 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). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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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GOAGO           GOAGO           GOAGO           G2011           G2083           G3397           G8396           G8397           G8397           G8399           G8404           G8404           G8410           G8417           G8418           G8419           G8421           G8423           G8424           G8423           G8423           G8423           G8433           G8433           G8434           G8435           G8452           G8453           G8473           G8474           G8475           G8476           G8477           G8478           G8478           G8478           G8478           G8478           G8483           G8483           G8484           G9050           G9050	active antiretroviral therapy.) Autolog pro not diab ulcer Autolog pro not diab ulcer Alcolog In dab wound ulcer Alcolog In diab wound ulcer Alcolog Indab wound ulcer Alcolog Indab wound ulcer Structured Assessment (E.G. Audit Dast) And Brief Intervention 5.14 Minutes Visit esketamine 56m or less Visit esketamine 55m IVEF=>40% doc normal or mild IVEF not performed Di macula/fundus exam/w doc Pl w/dxa nresults document Pl w/dxa nresults document Eval on foot documented Eval on foot not performed Di macula/fundus exam/w doc Alco bmi abw up param f/u Calc bmi abw parametters Bmi not calculated Docree ur meds by elig Cin Cur meds not document Pa wilan leef holice nor R Heita-bioc ra ffu Ser for dep not cpt doc rsn Beta-bioc ra ffu walaw leif AcE/ARB thxpy rx?d AcE/ARB thxpy rx?d AcE/ARB thxpy rx?d AcE/ARB thxpy rx?d AcE/ARB thxpy rx?d Br not performed/doc By sys-140 and/or dias >=90 BP not performed/doc Flu immunize not admin Charlespecified Case Magnit Charlespecified Case Magnit Charlespecified Case Magnit Docnely worku pervalita Charlespecified Case Magnit Docnely worku pervalita Charlespecified Case Magnit Docnely worku pervalita Charlespecified Case Magnit Docnely worku pervalita Docnely worku pervalita	EU: Procedur/service not remelused by the Pan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP). EU: Procedur/service not covered by the Pan. Not subject to pre-service review. MP Criteria: Procedur/service notiveered gaints Medical Policy Criteria. Submit of Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedur/service notiveered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by the Pan. Not subject to pre-service review. Not Covered: Procedur/service not covered by		_	- - - - - - - - - - - - - - - - - - -
GO4460           GO465           G2011           G2082           G2083           G3395           G8396           G8397           G8397           G8398           G8397           G8399           G8404           G8410           G8415           G8416           G8417           G8420           G8421           G8423           G8424           G8423           G8433           G8430           G8431           G8432           G8433           G8451           G8452           G8453           G84543           G8455           G8473           G8474           G8475           G8476           G8477           G8482	active antiretroviral therapy.) Autolog pro not diab ulcer Autolog pro not diab ulcer Alcobol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5.14 Minutes. Visit esketamine 56m or less Visit esketamine 55m UVEF>=40% doc normal or mild UVEF not performed Dil macula/lundus exam/w doc Pt w/dxa results document Pt w/dxa results document De use exemity neur not perfor Eval on foot documented Eval on foot documented Eval on foot documented Eval on foot documented Eval on foot documented Calc bmi abw up aram f/u Calc bmi aram f/u Calc bmi abw up aram f/u Calc bm	EU Procedur/jervice not rembursed by the Pian. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP). EU Procedur/jervice not rembursed by the Pian. Not subject to pre-service review. MP Criteria: Procedur/jervice not accored by the Pian. Not subject to pre-service review. MP Criteria: Procedur/jervice note accored by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice note accored by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice note accored by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice note accored by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice note accored by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review. Not Covered: Procedur/jervice not covered by the Pian. Not subject to pre-service review		_	_

G9053 G9054					
G9054	Onc expectant management pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
	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.	-	-	-
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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 Pain. 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 nsclc stg2 no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9065	Onc dx nsclc stg3A no progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9066	Onc dx nsclc stg3B-4 metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		
G9067	One dx nsele stgsb 4 metasta		-	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9068	Onc dx sclc/nsclc limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9069	Onc dx sclc/nsclc ext at dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9070	Onc dx sclc/nsclc ext unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
G9071	Onc dx brst stg1-2B HR nopro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
G9072	Onc dx brst stg1-2 noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_	-
G9073			-	-	-
	Onc dx brst stg3-HR no pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9074	Onc dx brst stg3-noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9075	Onc dx brst metastic/ recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9077	Onc dx prostate T1no progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
G9078	Onc dx prostate T2no progres		-	-	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9079	Onc dx prostate T3b-T4noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9080	Onc dx prostate w/rise PSA	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9083	Onc dx prostate unknwn nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9084	Onc dx colon t1-3 n1-2 no pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
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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 Pain. Not subject to pre-service review.	-	-	
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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.		_	-
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G9095	Onc dx rectal extent unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9096	Onc dx esophag T1-T3 noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
G9097	Onc dx esophageal T4 no prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9098	Onc dx esophageal mets recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9099			-	-	-
	Onc dx esophageal unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9100	Onc dx gastric no recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9101	Onc dx gastric p R1-R2noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9102	Onc dx gastric unresectable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9103	Onc dx gastric recurrent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-
G9104			-	_	-
	Onc dx gastric unknown NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9105	Onc dx pancreatc p R0 res no	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G9106	Onc dx pancreatc p R1/R2 no	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
G9107	Onc dx pancreatic unresectab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			_
G9108	Onc dx pancreatic unknwn NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	
G9109	Onc dx head/neck T1-T2no prg		-	-	
		Non Covered: Proceedure/contice not covered by the Blan. Not cubiect to pro-contice review.	_	-	_
		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.	- - -	-	-
	Onc dx head/neck T3-4 noprog Onc dx head/neck M1 mets rec				- - -
G9110		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - -	- - - -	-
G9110 G9111	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown	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.	- - - -	-	- - - - -
G9110 G9111 G9112 G9113	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-B no pr	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.	-	- - - - -	- - - - -
G9110 G9111 G9112 G9113 G9114	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-B no pr Onc dx ovarian stg1A-B or 2	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.	- - - - - -	-	- - - - - -
G9110 G9111 G9112 G9113 G9114 G9115	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or Z Onc dx ovarian stg3/4 noprog	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.	- - - - - - - - - - - -	-	- - - - - -
G9110 G9111 G9112 G9113 G9114	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-B no pr Onc dx ovarian stg1A-B or 2	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.	- - - - - - - - - - -	-	- - - - - - - -
G9110 G9111 G9112 G9113 G9114 G9115	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or Z Onc dx ovarian stg3/4 noprog	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.	- - - - - - - - - -	-	- - - - - - - - -
G9110 G9111 G9112 G9113 G9114 G9115 G9116	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or 2 Onc dx ovarian stg3/4 noprog Onc dx ovarian stg3/4 noprog	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.	- - - - - - - - - - - -	- - - -	- - - -
G9110 G9111 G9112 G9113 G9114 G9115 G9116 G9117 G9123	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or 2 Onc dx ovarian stg3/4 noprog Onc dx ovarian recurrence Onc dx ovarian unknown NOS Onc dx CML chronic phase	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.	- - - - - - - - - - - - - - - - - - -	- - - - -	- - - - - -
G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9117           G9123           G9124	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or 2 Onc dx ovarian stg3/4 noprog Onc dx ovarian recurrence Onc dx ovarian unknown NOS Onc dx CNL fronic phase Onc dx CML acceler phase	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.	- - - - - - - - - - - - - - - - - - -	- - - -	- - - -
G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9117           G9123           G9124           G9125	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 or 2 Onc dx ovarian stg3/4 noprog Onc dx ovarian stegurence Onc dx ovarian unknown NOS Onc dx CML chronic phase Onc dx CML chronic phase Onc dx CML sceler phase	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.	-	- - - - -	- - - - - -
G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9117           G9123           G9124	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no 2 Onc dx ovarian stg3/4 noprog Onc dx ovarian stg3/4 noprog Onc dx ovarian ste3/4 noprog Onc dx cML chronic phase Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML bast phase Onc dx CML plast phase	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.	-	- - - - -	- - - - - -
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G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9127           G9128           G9129           G9120           G9123           G9124           G9125           G9126           G9127           G9128           G9129           G9130           G9131           G9132           G9133           G9134           G9135           G9136           G9137           G9138           G9139           G9134           G9137           G9138           G9139           G9140           G9147           G9978	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no r Onc dx ovarian stg1A-8 no r Onc dx ovarian stg1A-8 no r Onc dx CM1 acted on the stg1A-8 no r Onc dx CM1 chronic phase Onc dx CML chronic phase Onc dx CML extension Onc dx CML base Status; Limited To Multiple Myeloma Systemic Disease Status; Limited To Multiple Myeloma Systemic Disease Status; Limited To Multiple Myeloma Medicare-Approved Demonstration Project) Onc dx mult myeloma stg2 hig Onc dx mult myeloma stg2 hig Onc dx mult myeloma unknown Onc dx NHL stg1 - 2 no relap no Onc dx NHL stg1 - 2 no relap no Onc dx NHL stg3 - 4 not relap Onc dx NHL s	Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered b	- - - - - - - - - - - - - - - - - - -		- - - - - - - - - - -
G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9123           G9124           G9125           G9126           G9127           G9128           G9129           G9130           G9131           G9132           G9133           G9134           G9135           G9136           G9137           G9138           G9139           G9139           G9134           G9135           G9136           G9137           G9138           G9139           G9140           G9147           G9978           G9978           G9978           G9980	Onc dx head/neck M1 mets rec Onc dx head/neck M1 mets rec Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-9 or Z Onc dx ovarian recurrence Onc dx CM in recurrence Onc dx CML intervention of the stg1A-8 or Z Onc dx CML intervention of the stg2A-8 or Z Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML stg1A-8 or Z Onc dx M1 meloma stg2 hig Onc dx mult myeloma stg2 hig Onc dx NHL stg12 hig Onc dx NHL relaps/refractor Onc dx NHL relaps/refractor Onc dx NHL relaps/refractor Onc dx NHL stg1 unknown Frontier extended stg3 demo Outpatient intravenous insult Treatment (OVIT) either pulsatile or continuous by any means guided by the susts of measurements forcraspriatory quotient; and/or urine urea nitrogen (ULN); and/or arterial venous or calibritary glucose; and/or potassium concentration Remote E/M New Pt 20Mins Remote E/M New Pt 30 Mins	Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered b	- - - - - - - - - - - - - - - - - - -		- - - - - - - - - -
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G9110           G9111           G9112           G9113           G9114           G9115           G9116           G9123           G9124           G9125           G9126           G9127           G9128           G9129           G9130           G9131           G9132           G9133           G9134           G9135           G9136           G9137           G9138           G9139           G9139           G9134           G9135           G9136           G9137           G9138           G9139           G9140           G9147           G9978           G9978           G9978           G9980	Onc dx head/neck M1 mets rec Onc dx head/neck M1 mets rec Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-9 or Z Onc dx ovarian recurrence Onc dx CM in recurrence Onc dx CML intervention of the stg1A-8 or Z Onc dx CML intervention of the stg2A-8 or Z Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML acceler phase Onc dx CML stg1A-8 or Z Onc dx mult myeloma stg2 hig Onc dx not stg1 met Onc dx NHL stg12 hig Onc dx NHL relaps/refractor Onc dx NHL relaps/refractor Onc dx NHL stg1 unknown Frontier extended stg3 demo Outpatient intravenous insultin Treatment (OVIT) either pulsatile or continuous by any means guided by the susts of measurements forcraspriatory quotient; and/or urine urea nitrogen (ULN); and/or arterial venous or calibritary glucose; and/or potassium concentration Remote E/M New Pt 20Mins Remote E/M New Pt 30 Mins	Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jervice not covered b	- - - - - - - - - - - - - - - - - - -		- - - - - - - - - - - -
G9110           G9111           G9112           G9113           G9114           G9115           G9123           G9124           G9125           G9126           G9127           G9128           G9129           G9130           G9131           G9132           G9133           G9134           G9135           G9136           G9137           G9138           G9139           G9140           G9978           G9980           G9980           G9981	Onc dx head/neck M1 mets rec Onc dx head/neck ext unknown Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-8 no pr Onc dx ovarian stg1A-9 or 2 Onc dx ovarian unknown NOS Onc dx CML chronic phase Onc dx CML acceler phase Onc dx CML stg1st phase Onc dx CML stg1st phase Onc dx CML stg1st phase Onc dx CML acceler phase Onc dx Nut resisting the phase Onc dx Nut response Demonstration Project J Onc dx nut myeloma unknown Onc dx Nut response Insultation Project J Onc dx Nut response Insultation Project I Onc dx N	Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/Jearvice not covered by the Plan. Not subject to pre-service review.	- - - - - - - - - - - - - - - - - - -		- - - - - - - - - - -

9985	Remote E/M Est. Pt 15Mins Remote E/M Est. Pt 25Mins	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.	-	-	-
			-	-	-
9986	Remote E/M Est. Pt 40Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
9987	Bpci Advanced In Home Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
046	Mental health service nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
047	Alcohol/drug abuse svc 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 required per	-	-	-
129	Abatacept injection	wir chreis, riocoul geriche renewel aganst meutar nich chreis, submit für recommende chinkal nenew (riestermination) to avoid pas-service renew. Froi Autorization may be required per contract agreement.	-	-	-
172	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.	-	-	_
180	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 required per	-	_	-
202	Injection alemtuzumab	contract agreement.	-	-	-
218	Inj olipudase alfa-rpcp 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	7/1/2023	_	Add effecrive 07/01/2023
219		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			07/01/2025
	Inj aval alfa-nqpt 4mg	contract agreement.	-	-	-
20	Alglucosidase alfa injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
21	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.	-	-	-
22	Inj. patisiran 0.1 mg	Contract operations and the second se			
	ng. patisitan o.z.mg	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	-	-	-
23	Inj givosiran 0.5 mg	mm chiera. Froceours/service reviewe against medical rolly chiera. Sound for weconimended chinical newew (Fredetermination) to avoid post-service review. Froi Autorization may be required per confract agreement.	-	-	-
24	Inj. lumasiran 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
25		contract agreement.	-	-	-
	Inj vutrisiran 1 mg	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
56	Alpha 1 proteinase inhibitor	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 required per	-	-	-
90	INJECTION BELIMUMAB 10 MG	contract greement.	-	-	-
91	Inj anifrolumab-fnia 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			
17		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			
17	Inj. benralizumab 1 mg	contract agreement.	-	-	-
55	Inj bezlotoxumab 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
57	Ini cerlinonase alfa 1 mg	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			
	Inj. cerliponase alfa 1 mg	contract agreement.	-	-	-
84	Injection burosumab-twza 1m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
86	AbobotulinumtoxinA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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	-	-	-
87	Inj rimabotulinumtoxinB	mm chiera. Procedurejse vice reviewe against medical point of recommended chinical news (Predetermination) to avoid post-service review. Proi Autorization may be required per confract agreement.	-	-	-
88	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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	-	-	-
i98	C-1 esterase cinryze	contract agreement.	-	-	-
38	Canakinumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
		contract agreement. 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			
17	Certolizumab pegol inj 1mg	contract agreement.	-	-	-
75	Collagenase clost hist inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	_	_	_
91	Inj crizanlizumab-tmca 5mg	Consists 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			
51	ing crizaninzurnab-crica bing	contract agreement.	-	-	-
81	Darbepoetin alfa non-esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
88	Epoetin beta non esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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	-	-	-
290	Ecallantide injection	wir chreis, riocoul geriche renewel aganst meutar nich chreis, submit für recommende chinka nenew (riestermination) to avoid pas-service renew. Froi Autorization may be required per contract agreement.	-	-	-
300	Eculizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
		contract agreement. 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	-	-	-
301	Injection edaravone 1 mg	contract agreement.	-	-	-
302	Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
03	Inj. ravulizumab-cwvz 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
05	Ini ovinasumah dark Ema	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			
05	Inj evinacumab-dgnb 5mg	contract agreement.	-	-	-
06	Injection inclisiran 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.	_	-	_
22	Elosulfase alfa injection	Contract specification and spe			
~~	Elosullase alla injection	contract agreement. MP Criteria's memory of the contract agreement of	-	-	-
25	Epoprostenol injection	We check the text we revewe against weich rout check automation recommended clinical revew (recerchinistical) to avoid partier were revew. Fill Automation may be required per contract agreement.	-	-	-
11	Inj hemgenix per tx dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023		Add effecrive
				-	05/01/2023
26 27	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
	Inj. viltolarsen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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	-	-	-
28	Inj eteplirsen 10 mg	contract agreement.	-	-	-
29	Inj golodirsen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
58	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.	-	_	_
51	loi cutaquia 100 mc	contract agreement. MP Criteria: Forcedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
,1	Inj cutaquig 100 mg	contract agreement.	-	-	-
54	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.	-	-	-
66	Immune globulin powder	Concest agreements Unitstef: Proceedime/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
99	lvig non-lyophilized NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_
02	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			
32		contract agreement. - ND Chindra agreement.	-	-	-
	Inj. brexanolone 1 mg	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
29	Inj hydroxyprogst capoat nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
3	Idursulfase injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
5	Infliximab not biosimil 10mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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	-	-	-
16	Inj. ibalizumab-uiyk 10 mg	MP Literia: Procedure/service reviewed against Medical Policy Literia. Submit for Recommended Linical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
7	Inj spesolimab-sbzo 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2023	_	Add effecrive
		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		-	05/01/2023
36	Injection Imiglucerase 10 Units	contract agreement.	-	-	-
23	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 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	-	-	-
31	Injection Laronidase 0.1 Mg	MP cherta. Proceedings were reversed against medical policy chiena. Submit for recommended chinkal nevers (predetermination) to avoid post-service reverse. Prior Authorization may be required per contract agreement.	-	-	-
51	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.			
54	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
		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		-	04/01/2023
32	Injection mepolizumab 1mg	contract agreement.	-	-	-
8	Ziconotide injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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. 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			
J2356	Inj tezepelumab-ekko 1mg	contract agreement.	-	-	-
J2357	Omalizumab injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per content because the service review.	_	-	_
J2440	Injection Papaverine Hcl Up To 60 Mg	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: Journit on Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per MP Criteria:	-	-	-
J2502	Inj pasireotide long acting	contract agreement.	-	-	-
J2503	Pegaptanib sodium injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
J2507	INJECTION PEGLOTICASE 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
J2777	Inj faricimab-svoa 0.1mg	contract agreement. 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. 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	-	-	-
J2786	Injection reslizumab 1mg	wind there a not contract against medical noise strategies and the continent of recommended clinical review (neucerinitation) to avoid post-service review. Prior Autorization 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			
32040	ing seperipase and 1 mg	contract agreement.	-	-	-
J3032	Inj. eptinezumab-jjmr 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
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			
13000	Injection rangidcerace Ana 10 Onits	contract agreement.	-	-	-
J3121	Inj testostero enanthate 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
J3145	Testosterone undecanoate 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
15145	restosterone undecanoate img	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.	-	-	-
12245	tet Athenticeren had ever	Which are agreement. Which are a set of the			
J3245	Inj. tildrakizumab 1 mg	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 required per contract agreement.	_	-	_
J3285	Treprestini intestion	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			
	Treprostinil injection	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 construction acression		_	_
		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			
J3380	Injection vedolizumab	min cliente, nuesua systemic reviewe against meanar noisy cinteria, submit for necommenced climical nerve (reviewe indiano) to avoid post-service reviewe nerve n	-	-	-
J3385	Injection Velaglucerase Alfa 100 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. 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	-		-
J3397	Inj. vestronidase alfa-vjbk	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. 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	-	-	-
13399	Inj onase abepar-xioi treat	wir chiefte. Processe zwie zwie werde against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for recommended chinkan revew (Predetermination) to avoid post-service revewer against westen Policy chiefte. Jubinit for reverse reverses against westen Policy chiefte. Jubinit for reverse reverses against westen Policy chiefte. Jubinit for reverses against westen Policy chiefte. Jubin	-	-	-
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.	-	-	-
		MP Criteria: Trocedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewe. Prior Authorization may be required per	-	_	-
J7178	Inj human fibrinogen con nos	contract agreement.	-	-	-
J7192	Factor viii recombinant NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			
		onisted. Procedure/service not specifically defined of 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.	-	-	-
	Factor ix recombinant nos Hemophilia clot factor noc		-		_ _ _
J7195	Factor ix recombinant nos Hemophilia clot factor noc Methyl Aminolevulinate (Mal) For Topical	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		_ 
J7195 J7199 J7309	Factor ix recombinant nos Hemophilia clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram	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.	_ _ _ _	_ _ _ _	- - -
J7195 J7199 J7309 J7316	Factor ix recombinant nos Hemophilia clot factor noc Methyl Aminolevulinate (Mal) For Topical	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewe. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewe.	-	- - - -	- - - -
J7195 J7199 J7309	Factor ix recombinant nos Hemophilia clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram	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.	- - - -	- - - - -	- - - - - -
J7195 J7199 J7309 J7316	Factor ix recombinant nos Hemophila dolf factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	- - - - -	- - - - - -	- - - - -
J7195 J7199 J7309 J7316 J7340	Factor ix recombinant nos Hemophila clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg Carbidopa levodopa ent 100ml	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. Prior Authorization may be required per contract agreement.	- - - - - -	- - - - - -	- - - - - -
J7195 J7199 J7309 J7316 J7340 J7402	Factor ix recombinant nos Hemophilia clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg Carbidopa levodopa ent 100ml Mometasone sinus sinuva	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	-	- - - - - - -	- - - - - - -
J7195           J7199           J7309           J7316           J7340           J7402           J7599	Factor ix recombinant nos Hemophila dot factor noc Methy Anniocevinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg Carbidopa levodopa ent 100ml Mometasone Sinus sinuva Immunosuppressive drug noc	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. Unlisted: 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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review.	- - - - - - - - - - - -	- - - - - - - - -	- - - - - - - - -
J7195           J7199           J7309           J7316           J7340           J7402           J7599           J7604	Factor ix recombinant nos Hemophila clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg Carbidopa levodopa ent 100ml Mometasone sirus sinuva Immunosuppressive drug noc Acetylcysteine comp unit Levalbuterol comp con	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. 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 not 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. EU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. EU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. 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). 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).	- - - - - - - - - - -	- - - - - - - - - - - - -	- - - - - - - - - - - -
J7195           J7199           J7309           J7316           J7340           J7402           J7599           J7604           J7607           J7609	Factor ix recombinant nos Hemophila clot factor noc Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram Injection Ocriplasmin 0.125 Mg Carbidopa levodopa ent 100ml Mometasone sinus sinuva Immunosuppressive drug noc Acetylcysteine comp unit Levalbuterol comp con Albuterol comp unit	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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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. Pror Authorization may be required per contract agreement. MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. EU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPC). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPC). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUU policy, which is one of our Clinical Payment and Coding Policy (CPC).	- - - - - - - - - - - - - -	- - - - - - - - - - - - -	-
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J8499	Out and the second stress				
J8499 J8597	Oral prescrip drug non chemo	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
18999	Antiemetic drug oral NOS Oral prescription drug chemo	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.	-	-	-
J9020	Asparaginase NOS	Unistee: Proceedure/service not specificative difference or classified, maybe subject to contract/clinical review.	-	-	-
			-	-	– Retire effective
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.	-	12/31/2022	12/31/2022
J9285	Inj olaratumab 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_
J9332	Inj efgartigimod 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_	_	_
19600	Porfimer sodium injection	contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
19999	Chemotherapy drug	WF Citeral - Froceburgs event evenewal against metural mark your accommended Linucal neveral (Frederinnation) to avoid post-service review.	-	-	-
K0005	Ultralightweight wheelchair	Unissed Procedure/smith y require Prior Autionization per contract agreement. 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 K0053	Other power whichr base	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	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	W/c component-accessory NOS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Subnit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0455	Pump uninterrupted infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0800	POV group 1 std up to 300lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0801	POV group 1 hd 301-450 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0802	POV group 1 vhd 451-600 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0806	POV group 2 std up to 300lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
к0807	POV group 2 hd 301-450 lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
к0808	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.	-	-	-
K0812	Power operated vehicle NOC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	
K0813	PWC gp 1 std port seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
K0814	PWC gp 1 std port cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
K0815	PWC gp 1 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
K0816	PWC gp 1 std cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
к0820	PWC gp 2 std port seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0821	PWC gp 2 std port cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
K0822	PWC gp 2 std seat/back	mr Criteria : rocedure/service reviewed agains medical roley criteria. Submit to recommende Clinical Review (Predetermination) to ado post-service review. MP Criteria : rocedure/service reviewed agains medical roley Criteria. Submit to Recommende Clinical Review (Predetermination) to ado post-service review.	-	-	-
K0822	PWC gp 2 std seat/back PWC gp 2 std cap chair	WF Citeria: Procedure/service reviewed against Medical Policy Citeria. Submit for Recommendee Clinical Review (Predetermination) to avoid post-service review. MF Citeria: Procedure/service reviewed against Medical Policy Citeria. Submit for Recommendee Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0823			-	-	-
	PWC gp 2 hd seat/back	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0825	PWC gp 2 hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0826	PWC gp 2 vhd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0827	PWC gp vhd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0828	PWC gp 2 xtra hd seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0829	PWC gp 2 xtra hd cap chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0830	PWC gp2 std seat elevate s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0831	PWC gp2 std seat elevate cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
K0835	PWC gp2 std sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	-
K0836	PWC gp2 std sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0837	PWC gp 2 hd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0838	PWC gp 2 hd sing pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
K0839	pure				_
	PWC gp2 vhd sing pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	_	
K0840		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
K0840 K0841	PWC gp2 vhd sing pow opt s/b PWC gp2 xhd sing pow opt s/b PWC gp2 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
	PWC gp2 xhd sing pow opt s/b PWC gp2 std mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-		-
K0841 K0842	PWC gp2 xhd sing pow opt s/b PWC gp2 std mult pow opt s/b PWC gp2 std mult pow opt cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
K0841 K0842 K0843	PWC gp2 xhd sing pow opt s/b PWC gp2 std mult pow opt s/b PWC gp2 std mult pow opt cap PWC gp2 hd mult pow opt s/b	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	-	-	-
K0841 K0842 K0843 K0848	PWC gp2 xhd sing pow opt s/b PWC gp2 xtd mult pow opt s/b PWC gp2 std mult pow opt cap PWC gp2 hd mult pow opt s/b PWC gp 3 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	-	-	-
K0841 K0842 K0843 K0848 K0849	PWC gp2 xhd sing pow opt s/b       PWC gp2 std mult pow opt s/b       PWC gp2 std mult pow opt s/b       PWC gp2 hd mult pow opt s/b       PWC gp3 std seat/back       PWC gp 3 std seat/back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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.	-	-	-
K0841 K0842 K0843 K0848 K0849 K0850	PWC gp2 xhd sing pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp2 hd mult pow opt s/b         PWC gp3 std seat/back         PWC gp3 hd cap hair         PWC gp3 hd 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.	-	-	-
K0841 K0842 K0843 K0848 K0849 K0850 K0851	PWC gp2 xhd sing pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp3 hd nult pow opt s/b         PWC gp3 std seat/back         PWC gp3 hd seat/back         PWC gp3 hd seat/back         PWC gp3 hd seat/back         PWC gp3 hd 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.	-	-	-
K0841 K0842 K0843 K0848 K0849 K0850 K0851 K0852	PWC gp2 xhd sing pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp3 std seat/back         PWC gp3 std seat/back         PWC gp3 hd seat/back         PWC gp3 vhd seat/back         PWC gp3 vhd 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (P	-	- - - - -	- - - - -
K0841 K0842 K0843 K0848 K0849 K0850 K0851 K0852 K0853	PWC gp2 xhd sing pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp2 std mult pow opt s/b         PWC gp3 std seat/back         PWC gp3 hd seat/back         PWC gp3 std 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinic	-	- - - - - - -	- - - - - -
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К1019	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).	_	_	_
К1020	Non-invasive vagus nerv stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
К1023	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 required per			
K1030		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 K1032	Non pneu comp control w/o ca	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).	-	-	-
K1032	Non pneum seq comp full leg	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).	-	-	-
	Non pneum seq comp half leg	EU: Procedure/service on 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	Initiate: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
L6026			-	-	-
L6611	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 reviewe.	-	-	-
16611	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.	-	-	-
L6880	CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
16020	PATTERNS INCLUDES MOTOR(S)				
L6920	Wrist disarticul switch ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6925	Wrist disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6930	Below elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6935	Below elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6940	Elbow disarticulation switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	-
L6945	Elbow disart myoelectronic c	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6950	Above elbow switch control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6955	Above elbow myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L6960	Shldr disartic switch contro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6965	Shldr disartic myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L6970	Interscapular-thor switch ct	min cheres indexe specific events against model on one control on recommended clinical Review (Predestimination) to avoid post-server events. MP Criteria - Proceeding-Server eventsed against model on one commended clinical Review (Predestimination) to avoid post-server events.		-	-
L6975			-	-	-
	Interscap-thor myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7008	Pediatric electric hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7009	Adult electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7040	Prehensile actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7045	Pediatric electric hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7170	Electronic elbow hosmer swit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7180	Electronic elbow sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7181	Electronic elbo simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	-
L7185	Electron elbow adolescent sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
L7186	Electron elbow child switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			
L7190	Elbow adolescent myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7191	Elbow child myoelectronic ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7364	Twelve volt battery utah/equ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		-	-
L7366	Battery chrgr 12 volt utab/e		-	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L7499	Upper extremity prosthes NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
L8039	Breast prosthesis NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
L8048	Unspec maxillofacial prosth	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_
L8499	Unlisted misc prosthetic ser	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
L8604	Dextranomer/hyaluronic acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	-	_
L8605	Inj bulking agent anal canal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		_	_
L8606	Synthetic implnt urinary 1ml	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_		_
L8608	Arg ii ext com/sup/acc misc	EU: Proceeding/service not reinforced by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
L8612	Aqueous shunt prosthesis	Los roceauris procedures processions and procession	-	-	-
	· ·	min Citeria: indexative service against wearant water and citeria. Submit to recommended clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per MP Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per MP Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per MP Criteria: Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
L8614	Cochlear Device	contract agreement.	-	-	-
L8615	Coch Implant Headset Replace	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			_
		contract agreement. 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			
L8616	Coch Implant Microphone Repl	MP Unterial Procedure/service reviewed against Medical Policy Unterial Submit for Recommended Unincal Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
L8617	Coch Implant Trans Coil Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
		contract agreement. 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	-	-	_
L8618	Coch Implant Tran Cable Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
	com npc	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.	-	-	-
18622	Deal Allelies Detter	comtract 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			
L8622	Repl Alkaline Battery	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.	_	_	_
10524		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			
L8624	Lith Ion Batt Cid Ear Level	contract agreement.	-	-	-
L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per	_		_
		contract agreement. 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			-
L8628	Cid Ext Controller Repl	MP Unterial Procedure/service reviewed against Medical Policy Unterial Submit for Recommended Unincal Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
L8629	Cid Transmit Coil And Cable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
10023	C.C. Carlanae Converte Cable	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 required per contract agreement.	-	-	-
18604	Ani Cad Dree Deal Furthering	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			
L8691	Aoi Snd Proc Repl Excl Actua	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 required per			
		contract agreement.		-	
L8699	Prosthetic implant NOS	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	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).	-	-	-

M0240	Casiri and imdev repeat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	_	Add effective 06/01/2023
M0241	Casiri and imdev repeat hm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023		Add effective
1010241	casin and indev repeat init	EID. Procedure/service not reinitionised by the main, not subject to pre-service review. Check Elo poincy, which is one or our chinical Payment and Coung Poincy (CPCP).	0/1/2025	-	06/01/2023
M0243	Casirivi and imdevi inj	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	-	Add effective 06/01/2023
M0244	Casirivi and imdevi inj hm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023		Add effective
				-	06/01/2023 Add effective
M0245	bamlan and etesev infusion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	-	06/01/2023
M0246	Bamlan and etesev infus home	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	_	Add effective 06/01/2023
P2031	Hair analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.			00/01/2025
P9020	Plaelet rich plasma unit	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).	-	-	-
P9099	Blood component/product noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	
Q0240	Casirivi and imdevi 600mg		6/1/2023	-	Add effective
Q0240	Casinyi and indevi buong	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	0/1/2025	-	06/01/2023
Q0243	casirivimab and imdevimab	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	-	Add effective 06/01/2023
Q0244	Casirivi and imdevi 1200 mg	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023		Add effective
00244	Casility and index 1200 mg	Loc Froceauleyserve not reinitiatised by the Finit, not subject to pre-serve review. Circls to poincy, which is one or our clinical regiment and coung roll y circly.	0/1/2023	-	06/01/2023 Add effective
Q0245	bamlanivimab and etesevima	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	-	06/01/2023
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 per	_	_	_
0.20.12	The second se	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			
Q2042	Tisagenlecleucel car-pos t	contract agreement.	-	-	-
Q2050	Doxorubicin inj 10mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
Q2052	lvig 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	Licocabiagono marz esc esc t	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			
	Lisocabtagene mara car pos t	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 Q4082	Splint supplies misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-
Q4082 Q4100	Drug/bio NOC part B drug CAP Skin substitute NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
Q4100 Q4101	Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
04101	Aprigram Oasis wound matrix	MP Cinteria: Proceeding-service reviewed against Medical Policy Cinteria. Submit for Recommended Cintical Review (Predetermination) to avoid post-service review. MP Cinteria: Proceeding-service reviewed against Medical Policy Cinteria. Submit for Recommended Cintical Review MP Cinteria: Proceeding-service reviewed against Medical Policy Cinteria. Submit for Recommended Cintical Review (Predetermination) to avoid post-service review.	-	-	-
Q4102 Q4103	Oasis wound matrix Oasis burn matrix		-	-	-
04104	Integra BMWD	EIU: Procedure/service not 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).	-	-	-
04105	Integra drt or omnigraft	Los noceaurgenes en temporares que entre entre entre entre e	-	-	-
04106	Dermagraft	min chera. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
Q4100 Q4107	Graftjacket	min checks index of the service review against metal and how you check a submit to recommended Linkal Review (index environmended Linkal Review (index environmended Environmended Linkal Review (index environmended Linkal Revi	-	-	-
Q4107	Integra matrix	M Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended (Linical Review (Predetermination) to avoid post service review.	-	-	-
Q4110	Primatrix	EU. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4111	Gammagraft	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4112	Cymetra injectable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4113	Graftjacket xpress	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4114	Integra flowable wound matri	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4115	Alloskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4118	Matristem micromatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4121	Theraskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4122	Dermacell awm porous sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	_
Q4123	ALLOSKIN RT PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4125	CENTIMETER ARTHROFLEX PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	
Q4125 Q4126	Memoderm/derma/tranz/integup	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).	-	-	-
Q4120 Q4127	TALYMED PER SQUARE CENTIMETER	EID. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EID poincy, which is one of our Clinical Payment and Coding Policy (CPCP). EID: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EID poincy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
04128	Flexhd/allopatchhd/sg.cm	Edu - Prodeculargence in orteninausea by the Prain, two subject to pre-service review. Create R10 pump, minimum site of our changence and pump review and pre-service review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site of our changence and pump review. Create R10 pump, minimum site our changence and pump review. Create R10	-	-	-
Q4128 Q4130	STRATTICE TM PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4130 Q4132	Grafix core grafixpl core	Ed. Frodeburgsenet in terminalised of the fails model and the failed of the failed	-	-	-
Q4132 Q4133	Grafix stravix prime pl sqcm	min checks not control and the second s	-	-	-
Q4133	hMatrix	min checks the second	-	-	-
Q4135	Mediskin	EU: Proceeding/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP).		-	
Q4136	EZderm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
Q4137	Amnioexcel biodexcel 1sq cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
Q4138	Biodfence dryflex 1cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4139	Amnio or biodmatrix inj 1cc	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
Q4140	Biodfence 1cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4141	Alloskin ac 1 cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4142	Xcm biologic tiss matrix 1cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4143	Repriza 1cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
Q4145	Epifix inj 1mg	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4146	Tensix 1cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4147	Architect ecm px fx 1 sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
Q4148	Neox neox rt or clarix cord	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	_
Q4149	Excellagen 0.1 cc	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	-	-
Q4150	Allowrap ds or dry 1 sq cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU 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.		-	-
Q4151	Amnioband guardian 1 sq cm	we criteria. Frocedure/service reviewed against wedicar forcy criteria. Submit for Neconimended critical Keview (Fredeterminiation) to avoid post-service review.	-		
Q4151 Q4152	Amnioband guardian 1 sq cm Dermapure 1 square 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).	-	_	-
			-	_	-
Q4152	Dermapure 1 square 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).	- - -	-	_ _ _
Q4152 Q4153	Dermapure 1 square cm Dermavest plurivest 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).	- - - -	- - -	

Q4156	Neox 100 or clarix 100	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	-
Q4157	Revitalon 1 square 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).	-	_	_
Q4158	Kerecis omega3 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).	-	_	_
Q4159	Affinity1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
Q4160	Nushield 1 square 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).	-	_	_
Q4161	Bio-connekt per square 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).	_	_	_
Q4162	Wndex flw bioskn flw 0.5cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
Q4163	Woundex bioskin 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).	-	_	-
Q4164	Helicoll per square 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).	-	-	_
Q4165	Keramatrix Kerasorb 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).	_	_	_
Q4166	Cytal per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	_
Q4167	Truskin per sq 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).	_	_	_
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q4169	Artacent wound 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).		_	_
Q4170	Cygnus 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).			_
Q4171	Interfyl 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			_
Q4173	Palingen or palingen xplus	EIU: Procedure/service 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).			-
Q4174	Palingen or promatrx	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			-
04175	Miroderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
Q4176	Neopatch or therion per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
04177	Floweramnioflo 0.1 cc	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP).		-	-
Q4177	Floweramniopatch 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).	-	-	-
Q4178 Q4179				-	-
Q4179 Q4180	Flowerderm 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).	-	-	-
	Revita 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).	-	-	-
Q4181	Amnio wound per square 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).	-	-	-
Q4182	Transcyte per sq 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).	-	-	-
Q4183	Surgigraft 1 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).		-	-
Q4184	Cellesta or duo 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).		-	-
Q4185	Cellesta flowab amnion 0.5cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	_	-
Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.		_	
Q4187	Epicord 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	-
Q4188	Amnioarmor 1 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).		_	_
Q4189	Artacent ac 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	_
Q4190	Artacent ac 1 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).			
Q4191	Restorigin 1 sq cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (PCP).		-	
Q4192	Restorigin 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
Q4192 Q4193	Coll-e-derm 1 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).	-	-	-
			-	-	-
Q4194	Novachor 1 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).	-	-	-
Q4195	Puraply 1 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).	-	-	-
Q4196	Puraply am 1 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).	-	-	-
Q4197	Puraply xt 1 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).	-	-	-
Q4198	Genesis amnio membrane 1sqcm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	_	-	-
Q4199	Cygnus matrix 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).	-	-	_
Q4200	Skin te 1 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).	_	-	_
Q4201	Matrion 1 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).	_	-	_
Q4202	Keroxx (2.5g/cc) 1cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	-	_	_
Q4203	Derma-gide 1 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).	_	_	_
Q4204	Xwrap 1 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).		_	_
Q4205	Membrane graft or wrap 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).			
Q4206	Fluid flow or fluid gf 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			
Q4208	Novafix 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).	-	-	-
Q4200 Q4209	Surgraft per sq cm				
Q4203	Surgrait per sq cili		_	_	
04210	Avalati araf dualaraf sa am	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		-	-
Q4210	Axoloti graf dualgraf 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).			-
Q4211	Amnion bio or axobio 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).		_ _ _ _	-
Q4211 Q4212	Amnion bio or axobio sq cm Allogen per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not 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).		-	- - - -
Q4211 Q4212 Q4213	Amnion bio or axobio 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).			-
Q4211 Q4212 Q4213 Q4214	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord 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).	- - - - - - -		
Q4211 Q4212 Q4213	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not 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).			- - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord 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).		- - - - - - - - - -	- - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotl ambient cryo 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not 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).		- - - - - - - - - - - -	- - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216	Amnion bio or axobio sq cm Allegen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotl ambient cryo 0.1 mg Artacent cord 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).			- - - - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216 Q4217	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotil ambient cryo 0.1 mg Artacent cord per sq cm Woundfix biowound plus xplus	EIU: Procedure/service not 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).			- - - - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216 Q4217 Q4218	Amion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotl ambient cry0.1 mg Artacent cord per sq cm Woundfik biowand plus xplus Surgicord 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			- - - - - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4215 Q4216 Q4217 Q4218 Q4219	Amnion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotl ambient cryo 0.1 mg Artacent cord per sq cm Woundfix biowound plus xplus Surgicord per sq cm Surgigraft dual 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			- - - - - - - - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216 Q4216 Q4217 Q4218 Q4219 Q4220	Amnion bio or axobio sq cm Allogen per cc Ascent: 0.5 mg Cellesta cord per sq cm Axolotl ambient: cryo 0.1 mg Artacent cord per sq cm Woundfix biowound plus xplus Surgicord per sq cm Surgicord qual per sq cm Bellacell HD. Surederm 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			- - - - - - - - - - - - - - - - - - -
Q4211 Q4212 Q4213 Q4214 Q4215 Q4216 Q4217 Q4218 Q4219 Q4220 Q4221	Amnion bio or axobio sq cm Allegen per cc Ascent 0.5 mg Cellesta cord per sq cm Axolotl ambient cryo 0.1 mg Artacent cord per sq cm Woundfix biowound plus xplus Surgicord per sq cm Burgigraft dual per sq cm Bellacell HO Surederm sq cm Anniowrap2 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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Q4211           Q4212           Q4213           Q4214           Q4215           Q4214           Q4215           Q4214           Q4215           Q4214           Q4215           Q4214           Q4220           Q4221           Q4222           Q4224           Q4225           Q4230           Q4231           Q4233           Q4234           Q4235           Q4236           Q4237           Q4238           Q4239           Q4234           Q4235           Q4236           Q4237           Q4238           Q4239           Q4240           Q4241           Q4245           Q4246           Q4247           Q4248           Q4249	Amion bio or axobio sq cm Allogen per cc Ascent 0.5 mg Cellesta cord per sq cm Avolotl ambient cryo 0.1 mg Artacent cord per sq cm Woundfix biowound plus xplus Surgicord per sq cm Surgicord per sq cm Bellicell HD Suederm sq cm Arniowrap2 per sq cm Progenamitrix per sq cm HH10-p per sq cm Anniokord per sq cm Cogenex annio memb per sq cm Cogenex flow amion 0.5 cc Corplex per sq cm Surfactor /nudyn per 0.5 cc Xeellerate per sq cm Corplex per sq cm Corpo-cord per sq cm Corpo-cord per sq cm Core-yte topical only 0.5 cc Polycyte topical only 0.5 cc Amniotex per cc Corretex per sq cm Amniotex per cc Corretex per cc Anniotex par cc Anniotex par cc Anniotex per cc Anniotex par cc Anniotype per sq cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not			

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	Mig 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
	Sugar a perse en		1/1/2025	-	01/01/2023 Add effective
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	-	01/01/2023
Q4265		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023		Add effective
					09/01/2023 Add effective
Q4265		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
Q4266		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023 Add effective
Q4266		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	06/01/2023; Retire effective 08/31/2023
Q4267		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	Add effective 09/01/2023
Q4267		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
Q4268		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	effective 08/31/2023 Add effective 09/01/2023
Q4268		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
Q4269		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	-	effective 08/31/2023 Add effective 09/01/2023
Q4269		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	Add effective 06/01/2023; Retire
Q4270		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	_	effective 08/31/2023 Add effective 09/01/2023
Q4270		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	09/01/2023 Add effective 06/01/2023; Retire
Q4271		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023		effective 08/31/2023 Add effective
Q4271		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	6/1/2023	8/31/2023	09/01/2023 Add effective 06/01/2023; Retire
Q5009	Hospice care NOS	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.		_	effective 08/31/2023
Q5103	Injection inflectra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per			
43103	injection innectra	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.	-	-	-
Q5106	Inj retacrit non-esrd use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	-
Q5109	Injection ixifi 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per contract agreement.	-	-	- Add effective
Q5121	Inj. avsola 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.	5/1/2023	6/30/2023	05/01/2023; Retire effective 06/30/2023
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 spray	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.	_	-	-
50117 50142	Tretinoin topical 5 g Colistimethate inh sol mg	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. 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	-	-	-
50142	Colistimethate inh sol mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Citeria: 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.	-	-	
50142 50157	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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	- - - -	- - - -	- - -
50142 50157 50197	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day	Non Covered: Procedure/service not covered by the Plan: Not subject to pre-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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - -	- - - -	- - - -
50142 50157 50197 50310	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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. 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.	- - - - - -	- - - - - -	-
S0142           S0157           S0197           S0310           S0320	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Citeria: 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. 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.	-	-	- - - - - - -
S0142           S0157           S0197           S0310           S0320           S0590	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv	Non Covered: Procedure/service rot covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorizaton may be required per contract agreement. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - - - - - -	- - - - - - - -	- - - - - -
S0142           S0157           S0197           S0310           S0320           S0590           S0622	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral tens serv Phys exam for college	Non Covered: 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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to cortact/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - - - - -	-	- - - - - - - - -
S0142           S0157           S0197           S0310           S0320           S0590           S0622           S0800	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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. 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. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Mn Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	-	-	- - - - - - - - - - -
S0142           S0157           S0197           S0310           S0320           S0590           S0622           S0800           S0810	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys eand for college Laser in situ keratomileusis Photorefractive keratectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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. 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. Unlisted: 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Precedure/service not covered by the Plan. Not subject to pre-service review.	-	-	- - - - - - - - - - - - - -
S0142           S0157           S0197           S0310           S0320           S0590           S0622           S0800           S0810           S1001	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item	Non Covered: 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. 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. Unlisted: 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Unlisted: Procedure/service rot covered by the Plan. Not subject to cortract/clinical review.	- - - - - - - - - - - - - - -		- - - - - - - - - - - - - - - - -
S0142           S0157           S0197           S0300           S0320           S0590           S0622           S0800           S0810           S1001           S1002           S1001           S1002           S1001           S1002           S1091           S2083	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratentomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band	Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorizaton may be required per contract agreement. Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorizaton may be required per contract agreement. 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: 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. 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.	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -
S0142           S0157           S0197           S0310           S0590           S0592           S0800           S0810           S1001           S1002           S1002           S1091           S2083           S2112	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv	Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorizaton may be required per contract agreement. 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to cortract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - - - - - - - - - - - - -	-	- - - - - - - - - - - - - - - - - - -
S0142           S0157           S0197           S0310           S0590           S0622           S0800           S0810           S1002           S1002           S1002           S1002           S1091           S2083           S2112           S2117	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar	Non Covered: 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. 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. Unlisted: 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. Non Covered: Procedure/service not specifically defined or classified, maybe subject to pre-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Covered: 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to 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 P	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -
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S0142           S0157           S0197           S0310           S0320           S0590           S0622           S0800           S0810           S1001           S1002           S1091           S2083           S2112           S2117	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar	Non Covered: 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. 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to contract/clinical review. MP Criteria: 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. EU: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -
S0142           S0157           S0197           S0310           S0320           S0590           S0622           S0800           S0810           S1001           S1002           S1092           S2083           S2083           S2112           S2117           S218	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar Total hip resurfacing	Non Covered: 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.         Non Covered: 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.         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 specifically defined or classified, maybe subject to contract/clinical review.         Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         Non Covered: 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.         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 Re	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	
S0142           S0157           S0197           S0310           S0590           S0622           S0800           S0810           S1001           S1002           S1001           S2083           S2012           S2112           S2117           S2118           S2120	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Deluxe item Custom item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar Total hip resurfacing Low Density Lipoprotein(Ldl)	Non Covered: 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. 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. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: 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. 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. 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 (CPC). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Revi	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	
S0142           S0157           S0197           S0310           S0590           S0590           S0622           S0800           S0101           S1001           S1002           S1001           S1002           S1001           S2083           S2112           S2117           S2118           S2120           S2140	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar Total hip resufracing Low Density Lipoprotein(Ldl) Cord blood harvesting	Non Covered: 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.         Non Covered: 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.         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 specifically defined or classified, maybe subject to contract/clinical review.         Non Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.         Non Covered: 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.         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 Re	- - - - - - - - - - - - - - - - - - -		
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S0142           S0157           S0197           S0320           S0590           S0590           S0600           S0810           S0810           S0810           S08010           S08010           S08010           S1001           S1001           S1001           S1001           S2083           S2112           S2118           S2120           S2202           S2203           S2204           S2205           S2206           S2207           S2208           S2209           S2209           S2409           S2411           S2409           S2401           S3600           S3650           S3650           S3650           S3650           S3650           S3650           S3900	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Physe sam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar Total hip resurfacing Cord blood-derived stem-cell BMT harv/transpl 28d pg Echoselerotherapy Implant suditory brain imp Arthroscop laser ther TTTS Surgical Techniques Requiring Use Of Robotic Surgical Fetoscop laser ther TTTS Surgical Techniques Requiring Use Of Robotic Surgical Stat lab home/nf Saliva test hormone level; Sali	Non Correct:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Unitsted:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not covered by the Plan. Not subject to pre-service review.         Non Coveret:       Procedure/jeavice not specifically defined or classified, maybe subject to contract/clinical review.         Non Coveret:       Procedure/jeavice not specifically defined or classified, maybe subject to contract/clinical review.         Nor Criteria:       Procedure/jeavice not specifically defined or classified, maybe subject to contract/clinical review.         Nor Criteria:       Procedure/jeavice not specifically defined or classified, maybe subject to contract/clinical review.         Nor Criteria:       Procedure/jeavice not specifically defined or classified, maybe subject to contract/clinical review.         Nor Criteria:       Procedure/jeavice not specifically defined or class			
S0142           S0157           S0197           S0310           S0320           S0590           S0520           S0800           S1001           S1001           S1001           S1002           S1091           S2020           S2112           S2118           S2120           S2202           S2202           S2200           S2300           S2409           S2409           S2400           S2400           S2400           S2400           S2400           S2400           S2400           S2400           S2400           S3650           S3652           S3652           S3652	Colistimethate inh sol mg Becaplermin gel 1%-0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-coronary propel Adjustment gastric band Knee arthroscp harv Arthroacrois subtalar Total hip resufracing Cord blood harvesting Cord blood harvesting Cord blood harvesting Cord blood harvesting Echosclerotherapy Implant semi-imp hear Implant auditory brain imp Arthroacrojal Lased pkg Echosclerotherapy Implant semi-imp kear Implant auditory brain imp Satituse Steparately in Addition To Code For Primary Procedure) Sata tab Stat tab home/nf Saliva test hormone level; Saliva test hormone level; Surface EMG	In or Goveral: Procedure/service network against Medical Policy Criteria Submit for Recommended Clinical Review (Predetermination) to avoid port-service review. Prior Authorization may be required periods in a converal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. On Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predeterminat			
S0142           S0157           S0157           S0197           S0320           S0590           S0590           S0590           S0590           S0500           S0810           S08010           S1001           S1001           S1002           S1091           S2083           S2112           S2112           S2140           S2142           S2150           S2203           S2235           S2300           S2403           S2404           S2401           S3600           S3601           S3603           S3603           S3604           S3605           S4015           S4015	Colistimethate inh sol mg Becaplermin gel 1%-0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Castom item Castom	In Convert Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Prior Authorization may be required per Rom Convert Procedure/service reviewed by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not convered by the Plan. Not subject to pre-service review. Non Convert Procedure/service not superflan/seffend or classified, maybe subject to contract/clinical review. Non Convert Procedure/service not superflan/seffend or classified, maybe subject to contract/clinical review. Non Convert Procedure/service not superflan/seffend or classified, maybe subject to contract/clinical review. Non Convert Procedure/service not superflan/seffend or classified, maybe subject to contract/clinical review. Non Convert Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Convert Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Convert Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Convert Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Non Convert Procedure/service reviewed ag			
S0142           S0157           S0197           S0310           S0320           S0590           S0800           S0800           S0800           S0800           S0800           S0800           S0800           S0800           S0800           S1001           S1002           S1091           S202           S2112           S2112           S2140           S2150           S2202           S2230           S2230           S2230           S2300           S2409           S4015           S3600           S3650           S3650           S3650           S4015           S4023	Colistimethate inh sol mg Becaplermin gel 1% 0.5 gm Prenatal vitamins 30 day Hospitalist Visit RN telephone calls to DMP Misc integral lens serv Phys exam for college Laser in situ keratomileusis Photorefractive keratectomy Deluxe item Custom item Stent non-cornary propel Adjustment gastric band Knee arthroscp harv Arthroereisis subtalar Total hip resurfacing Cord blood harvesting Cord blood harvesting Cord blood harvesting Cord blood harvesting Echosclerotherapy Implant semi-timp hear Implant auditory brain imp Arthroscopy shoulder surgi Fetal surg noc Fetason laser ther TTTS Surgical Techniques Requiring Use Of Robotic Surgical System (UIS Separately in Addition To Code For Primary Procedure) Stat lab State homone level; Saliva test hormone level; Surface EMG Complete UF nos case rate Incompl donor egg case rate	In or Goveral: Procedure/service network against Medical Policy Criteria Submit for Recommended Clinical Review (Predetermination) to avoid port-service review. Prior Authorization may be required periods in a converal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. On Covereal: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covereal: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predeterminat			

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.	_	_	_
S4990	Nicotine patch legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S4991	Nicotine patch nonlegend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
S5035	Hit Routine Device Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S5036	Hit Device Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S5100	Adult daycare services 15min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
S5101	Adult day care per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
S5102	Adult day care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S5105	Centerbased day care perdiem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S5108	Homecare train pt 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
S5109	Homecare train pt session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
\$5110	Family homecare training 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
\$5111	Family homecare train/sessio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
\$5115	Nonfamily homecare train/15m	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
\$5116	Nonfamily HC train/session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
S5120	Chore services per 15 min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_
S5121	Chore services per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_