

Predetermination, Post-Service Review and Non-Covered 2022 Commercial Benefit Procedure Code List

Posted November 2022

EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN, THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1, 2022.

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 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 predetermination, refer to our Utilization Management information on our website. You can also submit a request through Availity. https://www.availity.com/

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Procedure Code Groups	Procedure Code Group Description			
	Procedures/services reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.			
Medical Policy Criteria (MP Criteria)	ighlighted 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.			
1 ' ' '	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).			
Unlisted or Undefined	Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.			

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

${\bf Note: Some\ codes\ will\ appear\ twice\ if\ Ending\ Date\ and\ Effective\ Date\ are\ within\ the\ same\ quarter\ period.}$

Code	Code Description	Code Group & Description	Medical Policy No.	Medical Policy Title	Effective Date	Ending Date
00104	Anesth Electroshock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.013	Electroconvulsive Therapy	-	-
00640	Anesth Spine Manipulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	-
00797	Anesth Surgery For Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	-
11200	Removal Of Skin Tags <w 15<="" td=""><td>MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.</td><td>SUR716.001</td><td>Cosmetic and Reconstructive Procedures</td><td>_</td><td>9/30/2021</td></w>	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	9/30/2021
11200	Removal Of Skin Tags <w 15<="" td=""><td>Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.</td><td>-</td><td>-</td><td>10/1/2021</td><td>-</td></w>	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	10/1/2021	-
11201	Remove Skin Tags Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	9/30/2021
11201	Remove Skin Tags Add-On	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	10/1/2021	-
11920	Correct Skin Color 6.0 Cm/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11921	Correct Skn Color 6.1-20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_
11922	Correct Skin Color Ea 20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	_	_
11950	Tx Contour Defects 1 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	_	_
11951	Tx Contour Defects 1.1-5.0Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	_	_
11952	Tx Contour Defects 5.1-10Cc		SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	_	_
11954	Tx Contour Defects >10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	_	_
11960	Insert Tissue Expander(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
11970	Rplcmt Tiss Xpndr Perm Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.001	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures	_	-
11980	Implant Hormone Pellet(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.063 SUR717.001	Compounded Drug Products Gender Assignment Surgery and Gender Reassignment	_	_
15758	Free Fascial Flap Microvasc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.024	Surgery for Lipedema and Lymphedema	_	_
15769	Grfg Autol Soft Tiss Dir Exc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	1/15/2021	-
15771	Grfg Autol Fat Lipo 50 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	1/15/2021	-
15772	Grfg Autol Fat Lipo Ea Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	1/15/2021	-
15775	Hair Trnspl 1-15 Punch Grfts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	-
15776	Hair Trnspl >15 Punch Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-

15780	Dermabrasion Total Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment _ Surgery with Related Services
15781	Dermabrasion Segmental Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Nonpharmacologic Treatment of Rosacea Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment
15782	Dermabrasion Other Than Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Nonpharmacologic Treatment of Rosacea Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
15783	Dermabrasion Suprfl Any Site	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Nonpharmacologic Treatment of Rosacea Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
15786	Abrasion Lesion Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Nonpharmacologic Treatment of Rosacea Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment = - Surgery with Related Services
15787	Abrasion Lesions Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Somet with related set wes Arca Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment =
15788	Chemical Peel Face Epiderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Surgery With Notation Services Aren Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea
15789	Chemical Peel Face Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea
15792	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Norpharmscologic Treatment of Rosacea
15793	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Ann Management Chemical Peels Gender Assignment Surgery and Gender Reassignment
15820	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Notification (Continued of Notification (Continu
15821	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment
15822	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment _ Surgery with Related Services
15823	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment
15824	Removal Of Forehead Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR716.001 SUR717.001 SUR712.031	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services – – Surgical Deactivation of Headache Trigger Sites
15825	Removal Of Neck Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment
15826	Removal Of Brow Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR716.001 SUR717.001 SUR712.031	Surgery with Related Services Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services – – – Surgery with Related Services – – –
15828	Removal Of Face Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment
15829	Removal Of Skin Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures
15830	Exc Skin Abd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Upedema and Lymphedema
15832	Excise Excessive Skin Thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
15833	Excise Excessive Skin Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
15834	Excise Excessive Skin Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services — — — — — — — — — — — — — — — — — — —
15835	Excise Excessive Skin Buttck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery For Lipsedema and Lymphedema Control Con
15836	Excise Excessive Skin Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services — — — Surgery for Lipedema and Lymphedema
15837	Excise Excess Skin Arm/Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services — — — Surgery for Lipedema and Lymphedema
15838	Excise Excess Skin Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema
15839	Excise Excess Skin & Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024 SUR716.017	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services
15847	Exc Skin Abd Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR701.024	Surgical Treatment of Gynecomastia Cosmetic and Reconstructive Procedures Surgery for Lipedema and Lymphedema
15876	Suction Lipectomy Head&Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema

		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	
15877	Suction Lipectomy Trunk	predetermination to avoid post-service review.	SUR717.001 SUR701.024	Surgery with Related Services	
			301701.024	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Gender Assignment Surgery and Gender Reassignment	
15878	Suction Lipectomy Upr Extrem	predetermination to avoid post-service review.	SUR717.001 SUR701.024	Surgery with Related Services	
			301701.024	Surgery for Lipedema and Lymphedema	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment	
15879	Suction Lipectomy Lwr Extrem	predetermination to avoid post-service review.	SUR717.001 SUR701.024	Surgery with Related Services	
			30K701.024	Surgery for Lipedema and Lymphedema	
15999	Removal Of Pressure Sore	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	
		contract/clinicarreview.		Acne Management	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028	Laser Treatment of Congenital Port Wine Stain (PWS),	
17106	Destruction Of Skin Lesions	predetermination to avoid post-service review.	SUR704.008 THE801.030	Hemangiomas, and Other External Vascular Malformations	
			111202.030	Nonpharmacologic Treatment of Rosacea	
				Acne Management	
17107	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR704.008	Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular	
	Destruction of skill testons	predetermination to avoid post-service review.	THE801.030	Malformations	-
				Nonpharmacologic Treatment of Rosacea	
			THE801.028	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS),	
17108	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.008	Hemangiomas, and Other External Vascular	
		predetermination to avoid post-service review.	THE801.030	Malformations	
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Nonpharmacologic Treatment of Rosacea	
17340	Cryotherapy Of Skin	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE801.028	Acne Management	
		Policy (CPCP).			
17360	Skin Peel Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028	Acne Management	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	
17380	Hair Removal By Electrolysis	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment	
17000	Chia Tianna Da	Unlisted: Procedure/service not specifically defined or classified, may be subject to		Surgery with Related Services	
17999	Skin Tissue Procedure	contract/clinical review.	-	=	
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Other Than Liver, Prostate, or Dermatologic Tumors	
19300	Removal Of Breast Tissue	predetermination to avoid post-service review.	SUR716.017	Surgical Treatment of Gynecomastia	
19303	Most Simple Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	
13303	Mast Simple Complete	predetermination to avoid post-service review.	SUR716.015	Surgery with Related Services Risk-Reducing (Prophylactic) Mastectomy	
			SUR717.001	Gender Assignment Surgery and Gender Reassignment	
19316	Suspension Of Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR716.010	Surgery with Related Services	_
		require Prior Authorization per contract agreement.	SUR716.011	Mastopexy Reconstructive Breast Surgery	
			SUR716.001	Cosmetic and Reconstructive Procedures	
19318	December Destruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001	Gender Assignment Surgery and Gender Reassignment	
19510	Breast Reduction	require Prior Authorization per contract agreement.	SUR716.011	Surgery with Related Services Reconstructive Breast Surgery	
			SUR716.012	Reduction Mammaplasty	
19325	December 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment	
19525	Breast Augmentation W/Implt	predetermination to avoid post-service review.	SUR716.011	Surgery with Related Services Reconstructive Breast Surgery	
19328	Rmvl Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Breast Implant, Removal and/or Insertion	
	minimuce Breast impaire	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery Breast Implant, Removal and/or Insertion	
19330	Rmvl Ruptured Breast Implant	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	
			SUR716.009	Breast Implant, Removal and/or Insertion	
19340	Insj Breast Implt Sm D Mast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	
		predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	
			SUR716.009	Breast Implant, Removal and/or Insertion	
19342	Insj/Rplcmt Brst Implt Sep D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	
		predetermination to avoid post service review.	SUR716.011	Reconstructive Breast Surgery	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment	
19350	Breast Reconstruction	predetermination to avoid post-service review.	SUR716.011	Surgery with Related Services Reconstructive Breast Surgery	
19355	Correct Inverted Nipple(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	CUD716 001		
1,,,,,	correct inverted Nipple(5)	predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	<u> </u>
19357	Tiss Xpndr Plmt Brst Rcnstj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	
19370	Revj Peri-Implt Capsule Brst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery	
	. jpr. cupsuic bist	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Breast Implant, Removal and/or Insertion	
19371	Peri-Implt Capslc Brst Compl	predetermination to avoid post-service reviewe.	SUR716.011	Reconstructive Breast Surgery	<u> </u>
				Adipose-Derived Stem Cells in Autologous Fat Grafting	
			SUR716.021	to the Breast Handheld Radiofrequency Spectroscopy for	
19499	Breact Surger: Breachur-	MP Criteria: Procedure/service reviewed against Medical Criteria.	SUR701.037	Intraoperative Assessment of Surgical Margins During	
12422	Breast Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.031	Breast-Conserving Surgery	
			SUR716.011	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	
				Reconstructive Breast Surgery	
20527	Inj Dupuytren Cord W/Enzyme	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	_
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		2 1,411111111111111111111111111111111111	-
20560	Ndl Insj W/O Njx 1 Or 2 Musc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	_
		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 CPCP08, which is one of our Clinical Payment and Coding	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	
		Policy (CPCP).			
20983	Ablate Bone Tumor(S) Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors	
	** *	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Other Than Liver, Prostate, or Dermatologic Tumors	-
20985	Cptr-Asst Dir Ms Px	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	_
		Policy (CPCP). Unlisted: Procedure (considerant specifically defined or classified, may be subject to			
20999	Musculoskeletal Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	=	
21073	Mnpj Of Tmj W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Manipulation Under Anesthesia	
		predetermination to avoid post-service review.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	
21089	Prepare Face/Oral Prosthesis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	
				Cosmetic and Reconstructive Procedures	
			SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	
21120	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.030	Orthognathic Surgery	_
		predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical	_
			SUR705.010	Management Tomporomondibular laint (TMAI) Disorders (TMAID)	
1				Temporomandibular Joint (TMJ) Disorders (TMJD)	

				Cosmetic and Reconstructive Procedures		
			SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21121	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.030	Orthognathic Surgery		
		predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical	-	_
			SUR705.010	Management		
				Temporomandibular Joint (TMJ) Disorders (TMJD) Cosmetic and Reconstructive Procedures		
			SUR716.001	Gender Assignment Surgery and Gender Reassignment		
21122	December of Chile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Surgery with Related Services Orthognathic Surgery		
21122	Reconstruction Of Chin	predetermination to avoid post-service review.	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical	-	-
			SUR705.010	Management		
				Temporomandibular Joint (TMJ) Disorders (TMJD)		
			CURTACODA	Cosmetic and Reconstructive Procedures		
			SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21123	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.030	Orthognathic Surgery		
		predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical	-	-
			SUR705.010	Management		
				Temporomandibular Joint (TMJ) Disorders (TMJD) Gender Assignment Surgery and Gender Reassignment		
21125	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001	Surgery with Related Services		
		require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery		_
			SUR717.001	Gender Assignment Surgery and Gender Reassignment		
21127	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Surgery with Related Services Orthognathic Surgery		
	Augmentation cower saw bone	require Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical	-	-
				Management		
21145	Lefent I & Blace W/ Coofe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
21145	Lefort I-1 Piece W/ Graft	require Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
21146	Lefort I-2 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
		require Filor Authorization per contract agreement.	301703.010	remporomandibular some (Two) bisorders (Twob)		
21147	Lefort I 2/2 Diago W/ Croft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
	Lefort I-3/> Piece W/ Graft	require Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
		MD Critaria: Procedure (service reviewed against Mc Harl Callan Calland				
21150	Lefort li Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	_
		require i nor Authorization per contract agreement.				
21151	Lefort Ii W/Bone Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
-1131	corone in wy point of dits	require Prior Authorization per contract agreement.	301.703.030	or anogeneous gerry	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
21154	Lefort Iii W/O Lefort I	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	_
21155	Lefort Iii W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
		require Prior Authorization per contract agreement.			-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
21159	Lefort Iii W/Fhdw/O Lefort I	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21160	Lefort Iii W/Fhd W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
		require Prior Authorization per contract agreement.				_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
21188	Reconstruction Of Midface	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21206	Reconstruct Upper Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
		require Prior Authorization per contract agreement.				_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
21208	Augmentation Of Facial Bones	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21209	Reduction Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery	_	_
		require Prior Authorization per contract agreement.				
21248	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
21249	Reconstruction Of Jaw	service review.	-	-	-	-
21299	Cranio/Maxillofacial Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	,	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
21499	Head Surgery Procedure	contract/clinical review	-	-	_	_
21685	Hyoid Myotomy & Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical		
_1003	nyola wyotomy a suspension	predetermination to avoid post-service review.	351.700.003	Management	-	-
21899	Neck/Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
22505	Manipulation Of Color	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE903 016	Manipulation Under **		
22505	Manipulation Of Spine	predetermination to avoid post-service review.	i nedud.U16	Manipulation Under Anesthesia	-	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Percutaneous Intradiscal Electrothermal Annuloplasty,		
22526	Idet Single Level	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.023	Radiofrequency Annuloplasty, and Biacuplasty	1/1/2023	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Percutaneous Intradiscal Electrothermal Annuloplasty,	and the forms	
22526	Idet Single Level		SUR712.023	Radiofrequency Annuloplasty, and Biacuplasty	10/1/2022	12/31/2022
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Percutaneous Intradiscal Electrothermal Annuloplasty,		
22527	Idet 1 Or More Levels	Policy (CPCP).	SUR712.023	Radiofrequency Annuloplasty, and Biacuplasty	1/1/2023	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
22527	Idet 1 Or More Levels	predetermination to avoid post-service review.	CUR742 022	Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty	10/1/2022	12/21/2022
22527	Idet 1 Or More Levels	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR712.023	Radiofrequency Annuloplasty, and Biacuplasty	10/1/2022	12/31/2022
22586	Prescri Fuse W/ Instr L5-S1	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR712.038	Axial Lumbosacral Interbody Fusion	_	
		Policy (CPCP).				
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Interspinous Distraction (Spacers) and Interlaminar		
22867	Insj Stablj Dev W/Dcmprn	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Stabilization Devices	1/1/2023	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Interspinous Distraction (Spacers) and Interlaminar		
22867	Insj Stablj Dev W/Dcmprn	predetermination to avoid post-service review.	SUR712.029	Stabilization Devices	10/1/2022	12/31/2022
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Interspinous Distraction (Spacers) and Interlaminar		
22868	Insj Stablj Dev W/Dcmprn	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Stabilization Devices	1/1/2023	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Interspinous Distraction (Spacers) and Interlaminar		
22868	Insj Stablj Dev W/Dcmprn	predetermination to avoid post-service review.	SUR712.029	Stabilization Devices	10/1/2022	12/31/2022
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Interspinous Distraction (Spacers) and Interlaminar		
22869	Insj Stablj Dev W/O Dcmprn	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Stabilization Devices	1/1/2023	
	y y zanjen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Interspinous Distraction (Spacers) and Interlaminar		
22869	Insj Stablj Dev W/O Dcmprn	predetermination to avoid post-service review.	SUR712.029	Stabilization Devices	10/1/2022	12/31/2022
22005		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Interspinous Distraction (Spacers) and Interlaminar		
22003					4/4/2022	
22870	Insj Stablj Dev W/O Dcmprn	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.029	Stabilization Devices	1/1/2023	_
22870		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Interspinous Distraction (Spacers) and Interlaminar		_
	Insj Stablj Dev W/O Dcmprn	Policy (CPCP).	SUR712.029 SUR712.029		10/1/2022	12/31/2022

22899	Spine Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
22999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Criteria.	-	-	-	_
23929	Shoulder Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.032	Shoulder Resurfacing	_	_
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
24300	Manipulate Elbow W/Anesth	predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	_
24999	Upper Arm/Elbow Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
25259	Manipulate Wrist W/Anesthes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.016	Manipulation Under Anesthesia		
25000		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		<u> </u>		_
25999	Forearm Or Wrist Surgery	contract/clinical review	-	-	-	-
26340	Manipulate Finger W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	_
26341	Manipulat Palm Cord Post Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	_	_
26989	Hand/Finger Surgery	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Tialia/Tiliger Surgery	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	_
27275	Manipulation Of Hip Joint	predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	_
27279	Arthrodesis Sacroiliac Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.033	Sacroiliac Joint Fusion or Stabilization	_	_
27280	Fusion Of Sacroiliac Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.033	Sacrolliac Joint Fusion or Stabilization		PA End Dated
		require Prior Authorization per contract agreement until 09/30/2022		Facet Joint and Sacroiliac Joint Denervation		09/30/2022;
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR702.017 SUR705.019	Hip Resurfacing (HR)		
27299	Pelvis/Hip Joint Surgery	require Prior Authorization per contract agreement until 04/01/2022.	SUR705.036	Surgery for Groin Pain in Athletes Surgical Treatment of Femoroacetabular Impingement	-	-
			SUR705.029	(FAI)		
27412	Autochondrocyte Implant Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	Moved to PA list	12/31/2021
27599	Leg Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
27702	Reconstruct Ankle Joint	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.021	Total Ankle Replacement (TAR)		6/30/2022
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	-, -0, 2022
27703	Reconstruction Ankle Joint	predetermination to avoid post-service review.	SUR705.021	Total Ankle Replacement (TAR)	-	
27860	Fixation Of Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	_
27899	Leg/Ankle Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
20446		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	CURTOS 020	Autografts and Allografts in the Treatment of Focal		
28446	Osteochondral Talus Autogrft	require Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR705.020	Articular Cartilage Lesions	-	_
28890	Hi Enrgy Eswt Plantar Fascia	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_
		Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to		Musculoskeletal mulcations and 30tt rissue injuries		
28899	Foot/Toes Surgery Procedure	contract/clinical review.	-	-	-	-
29440	Addition Of Walker To Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
29799	Casting/Strapping Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
29862		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.029	Surgical Treatment of Femoroacetabular Impingement	1/1/2022	c /20 /2022
29002	Hip Arthr0 W/Debridement	predetermination to avoid post-service review.	5UR7U5.U29	(FAI) Autografts and Allografts in the Treatment of Focal	1/1/2022	6/30/2022
29866	Autgrft Impint Knee W/Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.020	Articular Cartilage Lesions		
23000	Autgrit implite knee wyscope	require Prior Authorization per contract agreement until 03/31/2022.	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
29868	Meniscal Trnspl Knee W/Scpe	predetermination to avoid post-service review. PA maybe required until 04/01/2022.	SUR705.034	Meniscal Allografts and Other Meniscal Implants	1/1/2022	6/30/2022
29914	Hip Arthro W/Femoroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until	SUR705.029	Surgical Treatment of Femoroacetabular Impingement	1/1/2022	
23314	The Artino W/Temoropiasty	04/01/2022.	301703.023	(FAI)	1/1/2022	_
29915	Hip Arthro Acetabuloplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.029	Surgical Treatment of Femoroacetabular Impingement	1/1/2022	
29915	Hip Arthro Acetabuloplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.	SUR705.029	(FAI)	1/1/2022	-
29915 29916	Hip Arthro Acetabuloplasty Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until	SUR705.029	(FAI) Surgical Treatment of Femoroacetabular Impingement	1/1/2022	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI)		-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.		(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI)		-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.029 SUR705.029 SUR705.041	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint		-
29916	Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria.	SUR705.029 SUR705.029	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondy/ar Interpositional Spacer as a Treatment of		-
29916	Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/202. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.029 SUR705.029 SUR705.041 SUR705.024	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability		-
29916	Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.029 SUR705.029 SUR705.041	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		- 10/31/2022
29916 29999 30400	Hip Arthro W/Labral Repair Arthroscopy Of Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.029 SUR705.029 SUR705.041 SUR705.024 SUR717.001 SUR706.001	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment	1/1/2022	- 10/31/2022
29916 29999	Hip Arthro W/Labral Repair Arthroscopy Of Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.029 SUR705.029 SUR705.041 SUR705.024 SUR717.001	(FAI) Surgical Treatment of Femoroacetabular Implingement (FAI) Surgical Treatment of Femoroacetabular Implingement (FAI) Surgical Treatment of Femoroacetabular Implingement (FAI) Instability Unicondylar interpositional Spacer as a Treatment of Junicompartmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment Surgery with Selated Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Selated Services	1/1/2022	- - 10/31/2022 10/31/2022
29916 29999 30400 30410	Hip Arthro W/Labral Repair Arthroscopy Of Joint Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.029 SUR705.029 SUR705.021 SUR705.024 SUR705.024 SUR717.001 SUR706.001 SUR717.001 SUR706.001	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar interpositional Spacer as a Treatment of Unicomoratmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Gender Assignment Surgery and Gender Reassignment	1/1/2022	
29916 29999 30400	Hip Arthro W/Labral Repair Arthroscopy Of Joint Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.029 SUR705.029 SUR705.021 SUR705.024 SUR717.001 SUR706.001	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicomartmental Arthritis of the Knee. Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	1/1/2022	
29916 29999 30400 30410 30420	Hip Arthro W/Labral Repair Arthroscopy Of Joint Reconstruction Of Nose Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.029 SUR705.029 SUR705.041 SUR705.024 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR706.001	(FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Gender Assignment Surgery and Gender Reassignment Surgery Agent Surgery Agent Surgery Agent Surgery	1/1/2022 - - -	10/31/2022
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32994	Ablate Pulm Tumor Perq Crybl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	_
32998	Ablate Pulm Tumor Perq Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	-	-
32999	Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
33211	Insert Card Electrodes Dual	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202 054	Biventricular Pacemakers (Cardiac Resynchronization		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Therapy) for the Treatment of Heart Failure Biventricular Pacemakers (Cardiac Resynchronization	-	-
33213	Insert Pulse Gen Dual Leads	predetermination to avoid post-service review.	MED202.054	Therapy) for the Treatment of Heart Failure	_	6/30/2022
33225	L Ventric Pacing Lead Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	-	6/30/2022
33267	EXCL LAA OPEN ANY METHOD	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation	10/1/2022	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Percutaneous and Surgical Closure of the Left Atrial		
33268	EXCL LAA OTH PX ANY METH	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.009	Appendage for Stroke Prevention in Atrial Fibrillation Percutaneous and Surgical Closure of the Left Atrial	10/1/2022	
33269	EXCL LAA THRSCP ANY METHOD	predetermination to avoid post-service review.	SUR701.009	Appendage for Stroke Prevention in Atrial Fibrillation	10/1/2022	_
33274	Tcat Insj/Rpl Perm Ldls Pm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.030	Leadless Cardiac Pacemaker	_	-
33275	Tcat Rmvl Perm Ldls Pm W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.030	Leadless Cardiac Pacemaker	_	-
33285	Insj Subq Car Rhythm Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection	-	-
22200		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Systems)		
33286	Rmvl Subq Car Rhythm Mntr	predetermination to avoid post-service review.	#IV/A	#N/A	_	3/31/2021
33289	Tcat Impl Wrls P-Art Prs Snr	predetermination to avoid post-service review.	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	-	6/30/2022
33418	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.025	Transcatheter Mitral Valve Procedures	10/1/2022	
33419	REPAIR TCAT MITRAL VALVE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.025	Transcatheter Mitral Valve Procedures	10/1/2022	_
33542	Removal Of Heart Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cardiac Restoration and Remodeling Procedures	_	
		predetermination to avoid post-service review.		Cardiac Restoration and Remodeling Procedures		
33999	Cardiac Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR707.026 SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation		
		contract/clinical review.	SUR703.027	Stem-Cell Therapy for the Treatment of Damaged	_	-
36299	Vessel Injection Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to		Myocardium Due to Ischemia		
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
36465	Njx Noncmpnd ScIrsnt 1 Vein	predetermination to avoid post-service review.	30K/07.016	Varicose Vein Management	-	_
36466	Njx Noncmpnd ScIrsnt Mlt Vn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
36468	Njx Sclrsnt Spider Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
36470	Njx ScIrsnt 1 Incmptnt Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
36471	Njx Scirsnt Mit Incmptnt Vn	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR707.016	Varicose Vein Management	-	-
36473	Endovenous Mchnchem 1St Vein	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	-	_
36474	Endovenous Mchnchem Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Varicose Vein Management	-	-
36475	Endovenous Rf 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	-
36476	Endovenous Rf Vein Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
36478	Endovenous Laser 1St Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		-	_	
36479	Endovenous Laser Vein Addon	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	-
36482	Endoven Ther Chem Adhes 1St	predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	-
36483	Endoven Ther Chem Adhes Sbsq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	-
36516	Apheresis Immunoads Slctv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE802.003	Lipid Apheresis	-	-
36522	Photopheresis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.026	Extracorporeal Photopheresis (ECP)		6/30/2022
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
37215	Transcath Stent Cca W/Eps	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Extracranial Carotid Angioplasty or Stenting	_	_
37216	Transcath Stent Cca W/O Eps			Extracranial Carotid Angioplasty or Stenting	-	-
37217	Stent Placemt Retro Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Extracranial Carotid Angioplasty or Stenting		_
37218	Stent Placemt Ante Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Extracranial Carotid Angioplasty or Stenting	_	_
37241	Vasc Embolize/Occlude Venous	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat		
37242		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Pelvic Conditions Therapeutic Embolization and Vessel Occlusion to Treat		
3/242	Vasc Embolize/Occlude Artery	predetermination to avoid post-service review.	SUR701.015	Pelvic Conditions Radioembolization for Primary and Metastatic Tumors	_	
			RAD601.047	of the Liver		
37243	Vasc Embolize/Occlude Organ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	_	-
			THE801.022	Transcatheter Arterial Chemoembolization (TACE) of		
37244	Vasc Embolize/Occlude Bleed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.015	the Liver Therapeutic Embolization and Vessel Occlusion to Treat		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Pelvic Conditions	_	
37500	Endoscopy Ligate Perf Veins	predetermination to avoid post-service review.	SUK/U/.U16	Varicose Vein Management	_	-
37501	Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
37700	Revise Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	-
37718	Ligate/Strip Short Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
37722	Ligate/Strip Long Leg Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	30K707.010		_	-
37735	Removal Of Leg Veins/Lesion	predetermination to avoid post-service review.		Varicose Vein Management	-	-
37760	Ligate Leg Veins Radical	predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
37761	Ligate Leg Veins Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	-	-
37765	Stab Phleb Veins Xtr 10-20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
I .		predetermination to avoid post-service review.		- '	-	-

37766	Phleb Veins - Extrem 20+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Varicose Vein Management	
37780	Revision Of Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	
37785	Ligate/Divide/Excise Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	
37799		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			
	Vascular Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	
38129	Laparoscope Proc Spleen	contract/clinical review.	-	-	
38204	Bl Donor Search Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.038 SUR703.038 SUR703.039 SUR703.041 SUR703.041 SUR703.042 SUR703.042 SUR703.045 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acutied Immunodeficiency Syndrome (GIDS) Hematopoietic Cell Transplantation for Acutied Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Amemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Milgnant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary	
38205	Harvest Allogeneic Stem Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.031 SUR703.034 SUR703.034 SUR703.035 SUR703.040 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.044 SUR703.045	Hematopoietic Cell Transplantation (HCI) or Additional Infusion following Preparative Segimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AlD) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Croncic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Amemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Milgnant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myelogroliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myelogroliferative Neoplasms (MPN) CEMS Syndrome (HCI) Transplantation for Plasma Cell Dyscrasia, Including Multiple Myeloma (MM) and PCEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasia, Including Multiple Myeloma (MM) and PCEMS Syndrome	

382066	5 Harvest Auto Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.045 SUR703.045 SUR703.040 SUR703.045 SUR703.045 SUR703.035 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acute Infusion (All Cell Transplantation for Acute Auguster Infusion (All Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Paesat Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small hymphocytic Lymphony (LL) Hematopoietic Cell Transplantation for Chronic Myelod Leukemia (ELL) Hematopoietic Cell Transplantation for Epithelial Hematopoietic Cell Transplantation for Genetic Diseases and Acquired America Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MSO) and Myeloporoliferative Neoplasms (MSN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome
38207	7 Cryopreserve Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.034 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (ANL) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphorynic Leukemia (CLL) and Small Lymphocytic Lymphorna (StLL) Hematopoietic Cell Transplantation for Chronic Myelool Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myelogroliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-lodgkin Lymphoma (SLL) Hematopoietic Cell Transplantation for Plasma Cell Disperasias, Including Multiple Myeloma (MM) and POEMS Syndrome
38208	3 Thaw Preserved Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.002 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.034 SUR703.040 SUR703.041 SUR703.042 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.030 SUR703.046 SUR703.046	Hematopoletic Cell Transplantation for Primary Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoletic Cell Transplantation as a Treatment of Acute Lympholastic Leukemia (ALI) Hematopoletic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoletic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AIMI) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AIMI) Hematopoletic Cell Transplantation for Central Nervous System Embryonal Turners and Ependymoma Hematopoletic Cell Transplantation for Central Nervous System Embryonal Turners and Ependymoma Hematopoletic Cell Transplantation for Chronic Lymphorytic Leukemia (CLI) and Small Lymphorytic Lymphorytic Leukemia (CLI) and Small Lymphorytic Lymphorytic Cell Transplantation for Chronic Myeloid Leukemia Hematopoletic Cell Transplantation for Epithelial Hematopoletic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoletic Cell Transplantation for Hodgkin Lymphoma (HI,) Hematopoletic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoletic Cell Transplantation for Miscellaneous Solid Turnors in Adults Hematopoletic Cell Transplantation for Myelodysplastic Syndromes (MOS) and Myeloproliferative Neoplasms (MPN) (MP

38209	Wash Harvest Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.040 SUR703.042 SUR703.042 SUR703.045 SUR703.045 SUR703.055 SUR703.055 SUR703.055 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional infusion following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Actute lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Actute Myelogenous Leukemia (ANL) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Fareast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Turnors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Turnors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphophoa (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome
38210	T-Cell Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.041 SUR703.042 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.055 SUR703.055 SUR703.055 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Auto Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphonytic Leukemia (CLL) and Small Lymphocytic Lymphona (SLL) Hematopoietic Cell Transplantation for Chronic Myelodi Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Benetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms (MPN) Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Myeloproliferative Necoplasms Hematopoietic Cell Transplantation for Phyelodysplastic Syndromes (MDS) and Phyelogysplastic Syndromes (MDS) an
38211	Tumor Cell Deplete Of Harvst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.041 SUR703.042 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.035 SUR703.040 SUR703.040 SUR703.040 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (FC) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) (Hematopoietic Cell Transplantation as a Treatment of Actute Lympholastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (ADS) (Host) (Host

38212	Rbc Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.003 SUR703.037 SUR703.037 SUR703.037 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.04 SUR703.035 SUR703.035 SUR703.040 SUR703.035 SUR703.040 SUR703.040 SUR703.035 SUR703.045 SUR703.045 SUR703.045 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Certa Revous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphoma (Stul) Lymphoma (Stul) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia (Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Modgkin Lymphoma (ILL) Hematopoietic Cell Transplantation for Modgkin Lymphoma (ILL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)	
				Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome	
38213	Platelet Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.003 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.029 SUR703.039 SUR703.031 SUR703.034 SUR703.035 SUR703.035 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045	Hematopoietic Cell Transplantation for Primary Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lympholastic Leukemia (ALU) Hematopoietic Cell Transplantation for Acquired Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myleologenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for General Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphono (ECL) Hematopoietic Cell Transplantation for Chronic Myleolid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Moligiant Lymphoma (HL) Hematopoietic Cell Transplantation for Moligiant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Migignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Moligiant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Moligiant Moligian Mo	
38214	Volume Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.035 SUR703.035 SUR703.039 SUR703.039 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.044 SUR703.044	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoclastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Mykelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphocytic Cell Transplantation for Chronic Mykeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Mykelodysplastic Syndromes (MDS) and Mykeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Mykeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Mykeloma (MM) and POEMS Syndrome	

38215	5 Harvest Stem Cell Concentrte	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.029 SUR703.041 SUR703.040 SUR703.040 SUR703.040 SUR703.035 SUR703.040 SUR703.035 SUR703.040 SUR703.045 SUR703.035 SUR703.044 SUR703.044	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Foliowing Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute tymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myvelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myvelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Freast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Turnors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Turnors and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Spithelial —— Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphoma Hematopoietic Cell Transplantation for Mon-Hodgkin Lymphoma Hematopoietic Cell Tran
38230	D Bone Marrow Harvest Allogen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.037 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.042 SUR703.035 SUR703.045 SUR703.045 SUR703.055	Hematooletic Cell Transplantation for Primary Hematopoletic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoletic Cell Transplantation as a Treatment of Acute Lymphobiastic Leukemia (ALU) Hematopoletic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AMU) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AMU) Hematopoletic Cell Transplantation for Autoimmune Diseases Hematopoletic Cell Transplantation for Reast Cancer Hematopoletic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoletic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoletic Cell Transplantation for Chronic Lymphoma (ELI) Hematopoletic Cell Transplantation for Chronic Myeloid Leukemia Hematopoletic Cell Transplantation for Central Diseases and Acquired Anemias Hematopoletic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoletic Cell Transplantation for Molgkin Lymphoma (HL) Hematopoletic Cell Transplantation for Molgkin Lymphoma (HL) Hematopoletic Cell Transplantation for Molgkin Lymphoma (HL) Hematopoletic Cell Transplantation for Myelodysplastic Syndromes (MOS) and Myeloproliferative Neoplasms (MPN) Hematopoletic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoletic Cell Transplantation for Polsma Cell Dyscrasias, Including Multiple Myeloma (MM) and DOEMS Syndrome Hematopoletic Cell Transplantation for Perimary
38232	2 Bone Marrow Harvest Autolog	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.041 SUR703.042 SUR703.042 SUR703.045 SUR703.045 SUR703.045 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055	infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Actue Lympholabistic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myvelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myvelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myveloid Leukemia (CLL) and Small Lymphocytic Cell Transplantation for Epithelial Hematopoietic Cell Transplantation for Senetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Molignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Polasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary

38240	0 Transpit Alio Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.035 SUR703.038 SUR703.029 SUR703.041 SUR703.031 SUR703.031 SUR703.032 SUR703.041 SUR703.035 SUR703.040 SUR703.040 SUR703.040 SUR703.055 SUR703.044 SUR703.055 SUR703.044 SUR703.044	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Actute Lympholastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Cell Transplantation for Chronic Lymphophoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Polasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome
3824:	1 Transpit Autol Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.002 SUR703.043 SUR703.047 SUR703.047 SUR703.035 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.031 SUR703.041 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation for Primary Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphong (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Molgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MOS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Polasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and
38242	2 Transpit Alio Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.035 SUR703.042 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.044	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Actute Lympholastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Cronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Leukemia (CLL) and Small Lymphocytic Cell Transplantation for Chronic Myleoid Leukemia (ELL) Hematopoietic Cell Transplantation for Epithelial Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Modgkin Lymphoma (HLL) Hematopoietic Cell Transplantation for Modgkin Lymphoma (Ell Transplantation for Modgkin Lymphoma (HLL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myleodysplastic Syndromes (MDS) and Myleoproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Poisma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary

38243	Transplj Hematopoletic Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.043 SUR703.043 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.045 SUR703.045 SUR703.045	Hematopoietic Cell Transplantation (HCT) or Additional Infusion following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acutie demonstration (All Section 1997) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma (Stul Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (Stul Lymphocytic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Molgian Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas (SMD) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Induling Multiple Myeloma (MM) and PCEMS Syndrome	-	-
38308	Incicion Of Lymph Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SLIP701 024	Hematopoietic Cell Transplantation for Primary		
	Incision Of Lymph Channels	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	35.7701.024	Surgery for Lipedema and Lymphedema	_	_
38589	Laparoscope Proc Lymphatic	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
38999	Blood/Lymph System Procedure	contract/clinical review.	-	-	-	-
39499	Chest Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
39599	Diaphragm Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_	_
40799	Lip Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_		_
40899	Mouth Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.		-		_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Radiofrequency Ablation (RFA) of Solid Tumors,		
41530	Tongue Base Vol Reduction	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.021 SUR706.009	Excluding Liver Sleep Related Breathing Disorders: Surgical Management	-	-
41599	Tongue And Mouth Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
41820	Excision Gum Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
41821	Excision Of Gum Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
41822	<u> </u>	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			-	-
	Excision Of Gum Lesion	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
41823	Excision Of Gum Lesion	service review.	-	-	-	-
41828	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
41830	Removal Of Gum Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
41870	Gum Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
41872	Repair Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
41874	Repair Tooth Socket	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, may be subject to	-	-	-	-
41899	Dental Surgery Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	Sleep Related Breathing Disorders: Surgical	-	-
42145	Repair Palate Pharynx/Uvula	predetermination to avoid post-service review.	SUR706.009	Management Disorders. Surgical	_	6/30/2022
42299	Palate/Uvula Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
42699	Salivary Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
42999	Throat Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
43206	Esoph Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	_
43210	Egd Esophagogastrc Fndoplsty	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.016	Device Therapies for Gastroesophageal Reflux Disease	_	6/30/2022
43236	Uppr Gi Scope W/Submuc Inj	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	CLIP716 002	(GERD) Bariatric Surgery Botulinum Toxin		·
	approximate III	predetermination to avoid post-service review.	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	-
43252	Egd Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Confocal Laser Endomicroscopy (CLE)	-	-
43253	Egd Us Transmural Injxn/Mark	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Device Therapies for Gastroesophageal Reflux Disease (GERD)		6/30/2022
43257	Egd W/Thrml Txmnt Gerd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	6/30/2022
43284	Laps Esophgl Sphnctr Agmntj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal	_	_
43289	Laparoscope Proc Esoph	predetermination to avoid post-service review. MP-Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.016	Reflux Disease (GERD) Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	6/30/2022
43499	Esophagus Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement until 03/31/2022.		-	-	_
43633	Removal Of Stomach Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery		
43644	Lap Gastric Bypass/Roux-En-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	_	-
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
43645	Lap Gastr Bypass Incl Smll I	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR716.003	Bariatric Surgery	12/1/2022	
43659	Laparoscope Proc Stom	contract/clinical review.	-	-	-	-

43770	Lap Place Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	-	_
43771	Lap Revise Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	-	-
43772	Lap Rmvl Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	-	-
43773	Lap Replace Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	-	-
43774	Lap Rmvl Gastr Adj All Parts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	_	_
43775	Lap Sleeve Gastrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43842	V-Band Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	_
43843	Gastroplasty W/O V-Band	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
43845	Gastroplasty Duodenal Switch	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery		
43846	Gastric Bypass For Obesity	predetermination to avoid post-service review.		Bariatric Surgery		
43847	Gastric Bypass Incl Small I	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003			
43848		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	-	
	Revision Gastroplasty	predetermination to avoid post-service review. MD Criteria: Procedure/convice reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	-	-
43886	Revise Gastric Port Open	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	301710.003	Bariatric Surgery	_	_
43887	Remove Gastric Port Open	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	-	-
43888	Change Gastric Port Open	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR716.003	Bariatric Surgery	_	-
43999	Stomach Surgery Procedure	contract/clinical review.	-	-	-	-
44238	Laparoscope Proc Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
44705	Prepare Fecal Microbiota	predetermination to avoid post-service review.	SUR703.049	Fecal Microbiota Transplantation (FMT)	-	6/30/2022
44799	Unlisted Px Small Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
44899	Bowel Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
44979	Laparoscope Proc App	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
45399	Unlisted Procedure Colon	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
45499	Laparoscope Proc Rectum	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
45999	Rectum Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	<u> </u>			
		contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
46707	Repair Anorectal Fist W/Plug	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR709.032	Plugs for Fistula Repair	-	-
46999	Anus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
47370	Laparo Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	-
47379	Laparoscope Procedure Liver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
47380	Open Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.029	Radiofrequency Ablation (RFA) of Primary or	_	_
47202		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.038	Metastatic Liver Tumors Microwave Tumor Ablation		
47382	Percut Ablate Liver Rf	predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	-
47399	Liver Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
47579	Laparoscope Proc Biliary	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
47999	Bile Tract Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement until 03/31/2022.	_	-	_	_
48999	Pancreas Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
49329	Laparo Proc Abdm/Per/Oment	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
49659	Laparo Proc Hernia Repair	contract/clinical review.	-	-	-	-
49999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
50250	Cryoablate Renal Mass Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	-	-
50360	Transplantation Of Kidney	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.007 SUR703.008	Kidney Transplant Liver Transplant and Combined Liver-Kidney Transplant		
30300	Transplantation of Ridney	predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	-	
50549	Laparoscope Proc Renal	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
50592	Perc Rf Ablate Renal Tumor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors,		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.021	Excluding Liver Cryosurgical Ablation of Miscellaneous Solid Tumors		
50593	Perc Cryo Ablate Renal Tum	unisted: Procedure/service not specifically defined or classified, may be subject to	SUR701.018	Other Than Liver, Prostate, or Dermatologic Tumors	-	_
50949	Laparoscope Proc Ureter	contract/clinical review.	-	Interestable Building Assess County To the Transport	-	-
51715	Endoscopic Injection/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	_	_
51999	Laparoscope Proc Bla	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
52327	Cystoscopy Inject Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.022	Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	-	
52441	Cystourethro W/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift	-	
52442	Cystourethro W/Addl Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift	_	
53855	Insert Prost Urethral Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.025	Temporary Prostatic Stent	-	-
53860	Transurethral Rf Treatment	Floatest Mindows (2014) Floatest State State (1994) Floatest State State (1994) Floatest State State (1994) Floatest State State State (1994) Floatest State	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	-	-
53899	Urology Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
54125	Removal Of Penis	contract/clinical review. MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for productions and the contract content of	SUR717.001	Gender Assignment Surgery and Gender Reassignment	_	_
54200	Treatment Of Panis 1 1	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Surgery with Related Services Clostridial Collagenase for Fibroproliferative Disorders		
J=200	Treatment Of Penis Lesion	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	-
54205	Treatment Of Penis Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatment	-	-
54235	Penile Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatment	-	-

F 4 400						
54400	Insert Semi-Rigid Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment		
54401	Insert Self-Contd Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment		
4405	Insert Multi-Comp Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment		
54660	Revision Of Testis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment		
	nevision of resus	predetermination to avoid post-service review.	SUR717.001	Surgery with Related Services		
4699	Laparoscope Proc Testis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
5559	Laparo Proc Spermatic Cord	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
,,,,,,	Laparo Proc Spermatic Coru	contract/clinical review.	-	- Caturation Dioney for Diagnosis Staging and	-	-
55706	Prostate Saturation Sampling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.015	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including	_	6/30/2022
		predetermination to avoid post-service review.		Comprehensive 3D Mapping with Biopsy		
55880	Abltj Mal Prst8 Tiss Hifu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer	2/1/2021	-
				High-Intensity Focused Ultrasound (HIFU) for		
55899	Genital Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.014 SUR701.031	Treatment of Cancer Magnetic Resonance Image Guided Laser Interstitial		
	- /	require Prior Authorization per contract agreement until 04/01/2022.	SUR710.019	Tumor Therapy (LITT)	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Nerve Graft With Radical Prostatectomy Gender Assignment Surgery and Gender Reassignment		
55970	Sex Transformation M To F	predetermination to avoid post-service review.	SUR717.001	Surgery with Related Services	-	_
55980	Sex Transformation F To M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
56805	Repair Clitoris	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment		
		predetermination to avoid post-service review.		Surgery with Related Services Gender Assignment Surgery and Gender Reassignment	-	-
56810	Repair Of Perineum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Surgery with Related Services	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment		
57291	Construction Of Vagina	predetermination to avoid post-service review.	SUR717.001	Surgery with Related Services	-	-
57292	Construct Vagina With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment		
57335	Repair Vagina	predetermination to avoid post-service review.	MED201.030	Surgery with Related Services	-	-
57426	Pavisa Brooth Van Craft I an	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment		
J/420	Revise Prosth Vag Graft Lap	predetermination to avoid post-service review.	30/1/1/001	Surgery with Related Services	-	-
58578	Laparo Proc Uterus	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
58579	Hysteroscope Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Laparoscopic. Percutaneous and Transcervical		
58674	Laps Abltj Uterine Fibroids	predetermination to avoid post-service review.	SUR701.033	Techniques for the Myolysis of Uterine Fibroids	-	6/30/2022
58679	Laparo Proc Oviduct-Ovary	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
58999	Genital Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	ocintal surgery resecute	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
59074	FETAL FLUID DRAINAGE W/US	predetermination to avoid post-service review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	12/1/2022	_
59897	Fetal Invas Px W/Us	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUP701 016	Fetal Surgery for Prenatally Diagnosed Malformations		6/30/2022
	retarilivas FX W/O3	contract/clinical review.	301701.010	retar surgery for Frenatally Diagnosed Wallormations	-	0/30/2022
59898	Laparo Proc Ob Care/Deliver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
59899	Materials Cons Broading	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
33033	Maternity Care Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
60659	Laparo Proc Endocrine	contract/clinical review.	-	-	-	-
60699	ENDOCRINE SURGERY PROCEDURE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.031	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	10/1/2022	
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	30R/01.031	Tumor Therapy (ETT)	10/1/2022	_
60699	Endocrine Surgery Procedure	contract/clinical review.	-	Diagnosis and Treatment of Chronic Cerebrospinal	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED202.064	Venous Insufficiency in Multiple Sclerosis		
61630	Intracranial Angioplasty	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED202.064 SUR701.027	Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including	-	-
61630	Intracranial Angioplasty			Intracranial Stenting or Angioplasty, including Endovascular Procedures	-	-
		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.027 MED202.064	Intracranial Stenting or Angioplasty, including Endovascular Procedures Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis	-	-
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61635 61645 61650	Intracran Angiopisty W/Stent Perq Art M-Thrombect &/Nfs Evasc Pring Admn Rx Agnt 1St	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.064 SUR701.027 SUR701.027 SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including Endovascular Procedures Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment	-	- 6/30/2022 - - 10/1/2022
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64581	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	_	10/1/2022
CAFOR	One Marki Hardal Materia And De	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	CUPTOC OOO	Sleep Related Breathing Disorders: Surgical	2022 05 04	
64582	Opn Mpltj Hpglsl Nstm Ary Pg	require Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR706.009	Management Intraosseous Radiofrequency Nerve Ablation of the	2022-05-01	=
64628	Trml Dstrj los Bvn 1St 2 L/S	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Basivertebral Nerve for the Treatment of Low Back Pain	2022-08-01	-
64628	Trml Dstrj los Bvn 1St 2 L/S	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-05-01	2022-07-31
64629	Trml Dstrj los Bvn Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Pallow (CRCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-08-01	-
64629	Trml Dstrj Ios Bvn Ea Addl	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back	2022-05-01	2022-07-31
64640	Injection Treatment Of Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.040	Pain Ablation of Peripheral Nerves to Treat Pain	5/15/2021	
64999	Nervous System Surgery	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RXS01.019 SUR703.003 SUR702.017 SUR712.024 SUR701.031 MED205.037 SUR712.033 MED205.032 MED205.035 MED205.036 MED205.039 MED201.039	Botulinum Toxin Brain Tissue Transplantation and Neurotransplantation Facet Joint and Sacrollial Joint Denervation Lysis of Epidural Adhesions Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Navigated Transcranial Magnetic Stimulation (nTMS) Nerve Graft With Radical Prostatectomy Occipital Nerve Stimulation Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy Percutaneous Tibial Nerve Stimulation (PTNS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNS) Sphenopalatine Ganglion Block for Headaches or Facial Pain Tumor Treating Fields (TTF) Therapy	-	-
65760	Revision Of Cornea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
65770	Revise Cornea With Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030	Keratoprosthesis	_	_
65785	Impltj Ntrstrml Crnl Rng Seg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Implantation of Intrastromal Corneal Ring Segments	_	_
66174	Translum Dil Eye Canal	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	301713.031	Viscocanalostomy and Canaloplasty	_	_
66175	Trnslum Dil Eye Canal W/Stnt	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Viscocanalostomy and Canaloplasty	_	_
66179	Aqueous Shunt Eye W/O Graft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	301713.032	Aqueous Shunts and Stents for Glaucoma	_	
66180		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	5/1/2021	
66183	Aqueous Shunt Eye W/Graft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		·	5/1/2021	_
	Insert Ant Drainage Device	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	-	
66989	Xcpsl Ctrc Rmvl Cplx Insj 1+	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	2022-03-15	
66991	Xcapsl Ctrc Rmvl Insj 1+	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR713.034	Aqueous Shunts and Stents for Glaucoma	2022-03-15	-
	Eye Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
67299	Eye Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
67399	Unlisted Px Extraocular Musc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
67599	Orbit Surgery Procedure	contract/clinical review.	-	-	-	-
67900	Repair Brow Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR716.004 SUR712.031	Blepharoplasty, Blepharoptosis and Brow Repair Surgical Deactivation of Headache Trigger Sites	-	-
67901	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	301710.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	_
67902	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67903	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67904	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	_
67906	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR/16.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	_
67908	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67999	Revision Of Eyelid	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
68399	Eyelid Lining Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
68899	Tear Duct System Surgery	Unlisted: Procedure/Service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
69090	Pierce Earlobes	contract/cinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
69300	Revise External Ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	
69399	Outer Ear Surgery Procedure	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
69705	Nps Surg Dilat Eust Tube Uni	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.018	Balloon Dilation of the Eustachian Tube	1/15/2021	_
69706	Nps Surg Dilat Eust Tube Bi	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Balloon Dilation of the Eustachian Tube	1/15/2021	
69714	Implant Temple Bone W/Stimul	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	_
69715	Temple Bne Implnt W/Stimulat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	12/31/2021
69717	Temple Bone Implant Revision	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
69718	Revise Temple Bone Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.003	Implantable Bone-Conduction and Bone-Anchored	_	12/31/2021
69799	Middle Ear Surgery Procedure	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	Hearing Aids	_	_
69930	Implant Cochlear Device	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
69949	Inner For Surgery Brees dive	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Inner Ear Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
69979	Temporal Bone Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
76496	Fluoroscopic Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
76497	Ct Procedure	contract/clinical review.	-	-	-	-

76498	Mri Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	-	_
76499	Radiographic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
76999	Echo Examination Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
77299	Radiation Therapy Planning	contract/clinical review.	-	-	-	-
77399	External Radiation Dosimetry	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
77499	Radiation Therapy Management	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
77799		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
77799	Radium/Radioisotope Therapy	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
78099	Endocrine Nuclear Procedure	contract/clinical review.	-	_	-	_
78199	Blood/Lymph Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
78299	Gi Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
78399	Musculoskeletal Nuclear Exam	contract/clinical review.	-	-	-	-
78499	Cardiovascular Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
78599	Respiratory Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
79600		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		<u>-</u>		
78699	Nervous System Nuclear Exam	contract/clinical review.	-	-	-	_
78799	Genitourinary Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	-	_
78999	Nuclear Diagnostic Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
79999	Nuclear Medicine Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
80299	Quantitative Assay Drug	contract/clinical review.	-	-	-	-
81099	Urinalysis Test Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
81422	Fetal Chrmoml Microdeltj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	AIM	AIM Guidelines	Moved to PA list	10/1/2019
		require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to				.,,
81479	Unlisted Molecular Pathology	contract/clinical review. May require PA per contract agreement.	MED208.089	-	-	_
81599	Unlisted Maaa	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
82523	Collagon Crosslinks	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated		
02323	Collagen Crosslinks	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	with High Bone Turnover	-	-
83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.158	Molecular Testing For Chronic Heart Failure and Heart Transplant	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Novel Biomarkers in Risk Assessment and Management		
83695	Assay Of Lipoprotein(A)	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	of Cardiovascular Disease	-	-
83698	Asses Universal Dis 2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	A450207.424	Measurement of Phospholipase A2 in the Assessment		
03090	Assay Lipoprotein Pla2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.134	of Cardiovascular Risk	-	-
83701	Lipoprotein Bld Hr Fraction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.009	Novel Biomarkers in Risk Assessment and Management		
03701	прорготент высти ттасцоп	Policy (CPCP).	WED207.008	of Cardiovascular Disease	-	_
83704	Lipoprotein Bld Quan Part	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.008	Novel Biomarkers in Risk Assessment and Management		
		Policy (CPCP).		of Cardiovascular Disease		_
83722	Lipoprtn Dir Meas Sd Ldl Chl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.008	Novel Biomarkers in Risk Assessment and Management		
		Policy (CPCP).		of Cardiovascular Disease		
83937	Assay Of Osteocalcin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated		_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		with High Bone Turnover		
83987	Exhaled Breath Condensate	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.024	Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders	-	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
84112	Eval Amniotic Fluid Protein	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	-	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
84431	Thromboxane Urine	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.148	Measurement of Thromboxane Metabolites in Urine	-	-
84999	Clinical Chemistry Test	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	<u> </u>	contract/clinical review.	-	-	-	-
85999	Hematology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
86001	Allergen Specific Igg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED206.001	Allergy Management		
	0	Policy (CPCP).		- U,		
86343	Leukocyte Histamine Release	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED206.001	Allergy Management		
		Policy (CPCP).				
86352	Cell Function Assay W/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.147	Immune Cellular Function Assay to Monitor and Predict Immune Function		_
86353	Lymphocyte Transformation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.088	Intracellular Micronutrient Analysis	_	_
86486		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		·		
	Skin Test Nos Antigen	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
86849	Immunology Procedure	contract/clinical review.	-	-	-	-
1		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
86910	Blood Typing Paternity Test		-	-	-	-
86910 86911	Blood Typing Paternity Test Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	<u>-</u>	<u>-</u>	-	-

86950	Leukacyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.002 SUR703.047 SUR703.037 SUR703.036 SUR703.039 SUR703.029 SUR703.041 SUR703.033 SUR703.040 SUR703.040 SUR703.040 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lympholastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Self Transplantation for Myelodysplastic Self Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPM) and POEMS Syndrome	·	-
86999	Transferriga Drasadura	Unlisted: Procedure/service not specifically defined or classified, may be subject to		Hematopoietic Cell Transplantation for Primary		
	Transfusion Procedure	contract/clinical review. MR Criteria: Procedure/service reviewed against Medical Bolicy Criteria: Submit for	-	-	-	-
87505	Nfct Agent Detection Gi	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	Gastrointestinal Panels	-	_
87506	ladna-Dna/Rna Probe Tq 6-11	predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	-	_
87507	ladna-Dna/Rna Probe Tq 12-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	_	_
87797	Detect Agent Nos Dna Dir	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
87798	Detect Agent Nos Dna Amp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
87799	Detect Agent Nos Dna Quant	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
87899	Agent Nos Assay W/Optic	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
87999	Microbiology Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
88000	Autopsy (Necropsy) Gross	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
88005	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
88007	Autopsy (Necropsy) Gross	service review.	-	-	-	-
88012	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
88014	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
88016	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
88020	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
88025	Autopsy (Necropsy) Complete	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
88027	Autopsy (Necropsy) Complete	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
88028		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	Autopsy (Necropsy) Complete	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
88029	Autopsy (Necropsy) Complete	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
88036	Limited Autopsy	service review.	-	-	-	-
88037	Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
88040	Forensic Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
88045	Coroners Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
88099	Necropsy (Autopsy) Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.				
55533	opsy (nacopsy) riocedule	Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
88199	Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
88299	Cytogenetic Study	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
88375	Optical Endomicroscpy Interp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
88399	Surgical Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_	-
88749	In Vivo Lab Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
89240	Pathology Lab Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
89258		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
	Cryopreservation Embryo(S)	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	Constant for the form the	-	-
89259	Cryopreservation Sperm	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
89335	Cryopreserve Testicular Tiss	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	
89337	Cryopreservation Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
89342	Storage/Year Embryo(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	
89343	Storage/Year Sperm/Semen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
89344	Storage/Year Reprod Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
89346	Storage/Year Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
		service review.				

		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
89398	Unlisted Reprod Med Lab Proc	contract/clinical review.	-	Author Contract Disorder (ACD)	-	-
90283	Human Ig Iv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	PSY301.014 RX504.003	Autism Spectrum Disorders (ASD) Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	11/30/2022
90284	Human Ig Sc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	11/30/2022
90378	Rsv Mab Im 50Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	-	-
90399	Immune Globulin	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	-	-
90584	Dengue Vacc Quad 2 Dose Subq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	7/1/2022	_
90689	Vacc liv4 No Prsrv 0.25Ml Im	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
90749	Vaccine Toxoid	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-		_
90867		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for	-	-
	Tcranial Magn Stim Tx Plan	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	731301.013	Psychiatric/Neurologic Disorders Transcranial Magnetic Stimulation as a Treatment for	_	
90868	Tcranial Magn Stim Tx Deli	predetermination to avoid post-service review.	PSY301.015	Psychiatric/Neurologic Disorders	-	_
90869	Tcran Magn Stim Redetemine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	-	_
90870	Electroconvulsive Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.013	Electroconvulsive Therapy	-	_
			PSY301.018 PSY301.017	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.019	Constipation Biofeedback as a Treatment of Headache		
90875	Psychophysiological Therapy	predetermination to avoid post-service review.	PSY301.016 PSY301.007	Biofeedback as a Treatment of Urinary Incontinence	-	-
			PSY301.011 MED205.022	Biofeedback for Miscellaneous Indications Neurofeedback		
			PSY301.018	Treatment of Tinnitus Biofeedback as a Treatment of Chronic Pain		
			PSY301.017	Biofeedback as a Treatment of Fecal Incontinence or Constipation		
90876	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.019 PSY301.016	Biofeedback as a Treatment of Headache		
		predetermination to avoid post-service review.	PSY301.007 PSY301.011	Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications	_	_
			MED205.022	Neurofeedback Treatment of Tinnitus		
90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.001	Hypnosis	_	6/30/2022
00000	U	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			7/4/2022	
90880	Hypnotherapy	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	7/1/2022	-
90885	Psy Evaluation Of Records	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
90889	Preparation Of Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
90899	Psychiatric Service/Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
			PSY301.018	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or		
			PSY301.017 PSY301.019	Constipation		
90901	Biofeedback Train Any Meth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.016	Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence	_	_
			PSY301.007 PSY301.011	Biofeedback for Miscellaneous Indications Neurofeedback		
			MED205.022	Treatment of Tinnitus		
90912	Bfb Training 1St 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.017 PSY301.016	Biofeedback as a Treatment of Fecal Incontinence or Constipation	4/1/2021	_
				Biofeedback as a Treatment of Urinary Incontinence Biofeedback as a Treatment of Fecal Incontinence or		
90913	Bfb Training Ea Addl 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.016	Constipation Biofeedback as a Treatment of Urinary Incontinence	4/1/2021	-
90999	Dialysis Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
91034	Gastroesophageal Reflux Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.005	Esophageal pH Monitoring	_	_
91035	G-Esoph Reflx Tst W/Electrod	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.005	Esophageal pH Monitoring	_	_
91037	Esoph Imped Function Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.005	Esophageal pH Monitoring	_	_
91038	Esoph Imped Funct Test > 1Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.005	Esophageal pH Monitoring	_	_
91065	Breath Hydrogen/Methane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.161	Hydrogen or Methane Breath Testing	_	_
91110	Gi Tract Capsule Endoscopy	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		The Small Bowel, Esophagus, and Colon Wireless Capsule Endoscopy (WCE) To Diagnose		_
91111	Esophageal Capsule Endoscopy	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Disorders of The Small Bowel, Esophagus, And Colon	-	-
91112	Gi Wireless Capsule Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.017	Gastrointestinal (GI) Motility Measurement		
	,	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		. , ,		
01112	CLTDC IMC INTDAL COLONISD	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Missalars Consula Endargon to Discourse Discourse	1 1/1/2022	
91113	GI TRC IMG INTRAL COLON I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wireless Capsule Endoscopy to Diagnose Disorders of T Wireless Capsule Endoscopy to Diagnose Disorders of		_
91113	GI TRC IMG INTRAL COLON I&R	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.042	The Small Bowel, Esophagus, and Colon	11/1/2022	12/31/2022
91117	Colon Motility 6 Hr Study	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.017	Gastrointestinal (GI) Motility Measurement	-	_
91132	Electrogastrography	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	-	-
91133	Electrogastrography W/Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	-	-
91299	Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
92015	Determine Refractive State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
92065	Orthoptic/Pleoptic Training	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	a. Stopstey recopute training	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	Ontical Cohorance Tomography of the Autual	-	-
92132	Cmptr Ophth Dx Img Ant Segmt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.021	Optical Coherence Tomography of the Anterior Eye Segment	-	-
92145	Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.031	Corneal Hysteresis	_	_
92340	Eit Spectacles Monofosal	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Fit Spectacles Monofocal	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
92341	Fit Spectacles Bifocal	service review.	-	-	-	-

		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
92342	Fit Spectacles Multifocal	service review.	-	-	_	_
92354	Fit Spectacles Single System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
92355	Fit Spectacles Compound Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
92370	Repair & Adjust Spectacles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
92499	Eye Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
03543	Need Constant Charles	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	NAT D 204 004	Rhinomanometry, Acoustic Rhinometry, Optical		
92512	Nasal Function Studies	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	WED204.004	Rhinometry and Acoustic Pharyngometry	-	-
92517	Vemp Test I&R Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.047	Vestibular Function Testing	5/15/2021	_
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				-1
92517	Vemp Test I&R Cervical	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.047	Vestibular Function Testing	2/15/2021	5/14/2021
92518	Vemp Test I&R Ocular	review. Check EIU policy CPCP08, which is one of our $$ Clinical Payment and Coding $$	MED201.047	Vestibular Function Testing	5/15/2021	_
92518	Vemp Test I&R Ocular	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.047	Vestibular Function Testing	2/15/2021	5/14/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				3/ - 1/
92519	Vemp Tst I&R Cervical&Ocular	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Vestibular Function Testing	5/15/2021	-
92519	Vemp Tst I&R Cervical&Ocular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.047	Vestibular Function Testing	2/15/2021	5/14/2021
92546	Sinusoidal Rotational Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.047	Vestibular Function Testing	_	_
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
92548	Cdp-Sot 6 Cond W/I&R	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	-	-
92549	Cdp-Sot 6 Cond W/I&R Mct&Adt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MFD205.026	Dynamic Posturography		
	cap soc o coma wynan wetarac	Policy (CPCP).		Synamic i Ostalography		-
92640	Aud Brainstem Implt Programg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR714.009	Auditory Brainstem Implant	-	_
92700	Ent Procedure/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
93050	Art Pressure Waveform Analys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED202.070	Non-Invasive Measurement of Central Blood Pressure		
		Policy (CPCP).		(cBP) Long-Term Ambulatory Cardiac Monitoring (Outpatient	_	
93228	Remote 30 Day Ecg Rev/Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003	Cardiac Telemetry, Implantable Cardiac Rhythm Event		
		predetermination to avoid post-service review.		Monitors, and Intracardiac Ischemia Detection Systems)		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event		
93229	Remote 30 Day Ecg Tech Supp	predetermination to avoid post-service review.	MED202.003	Monitors, and Intracardiac Ischemia Detection	-	-
93660	Tilt Table Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.048	Systems) Tilt Table Testing		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Bioimpedance Devices for Detection and Management		_
93702	Bis Xtracell Fluid Analysis	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.036	of Lymphedema	-	-
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	PAD601 014	Thermography		
	remperature dradient stadies	Policy (CDCD)		пстобирну	-	-
93797	Cardiac Rehab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Cardiac Rehabilitation (CR)	_	_
93798	Cardiac Rehab/Monitor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	_	_
93799	Cardiovascular Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
93998	Noninvas Vasc Dx Study Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
		contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
94014	Patient Recorded Spirometry	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	-	-
94015	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.040	Home Spirometry		
	· · · · · ·	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
94016	Review Patient Spirometry	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.040	Home Spirometry	_	_
94452	Hast W/Report	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-		_
94453	Hast W/Oxygen Titrate	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	_
94799	Pulmonary Service/Procedure	contract/clinical review.	-	-	_	_
95060	Eye Allergy Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
95065	Nose Allergy Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	-	-
95199	Allergy Immunology Services	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
05705		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Ambulatory or Video Electroencephalogram (EEG)		
95700	Eeg Cont Rec W/Vid Eeg Tech	predetermination to avoid post-service review.	MED205.008	Monitoring, Including Digital Analysis of Electroencephalogram	_	-
95705	Eeg W/O Vid 2-12 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	
		predetermination to avoid post-service review.		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)		
95706	Eeg Wo Vid 2-12Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Monitoring, Including Digital Analysis of	_	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)		
95707	Eeg W/O Vid 2-12Hr Cont Mntr	predetermination to avoid post-service review.	MED205.008	Monitoring, Including Digital Analysis of Electroencephalogram		
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	_
		predetermination to avoid post-service review.		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)		
95709	Eeg W/O Vid Ea 12-26Hr Intmt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Monitoring, Including Digital Analysis of	_	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)		
95710	Eeg W/O Vid Ea 12-26Hr Cont	predetermination to avoid post-service reviewe.	MED205.008	Monitoring, Including Digital Analysis of Electroencephalogram		
95711	Veeg 2-12 Hr Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of		
	I II III Oillioned	predetermination to avoid post-service review.		Electroencephalogram		
95712	Veeg 2-12 Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	_
		MD Criteria: Dracedure /consise regioned against Madical Delia: Criteria Submit for		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)		
95713	Veeg 2-12 Hr Cont Mntr	predetermination to avoid post-service reviewe.	MED205.008	Monitoring, Including Digital Analysis of Electroencephalogram	-	-
1						

95714	Veeg Ea 12-26 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95715	Veeg Ea 12-26Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95716	Veeg Ea 12-26Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	-	-
95718	Eeg Phys/Qhp 2-12 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	-	-
95719	Eeg Phys/Qhp Ea Incr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	-
95720	Eeg Phy/Qhp Ea Incr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	_
95721	Eeg Phy/Qhp>36<60 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of	_	_
95722	Eeg Phy/Qhp>36<60 Hr W/Veeg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of		
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of		
95724	Eeg Phy/Qhp>60<84 Hr W/Veeg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of		
95725	Eeg Phy/Qhp>84 Hr W/O Vid	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)	-	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Monitoring, Including Digital Analysis of Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)	_	_
95726 95803	Eeg Phy/Qhp>84 Hr W/Veeg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95803	Actigraphy Testing Motor &/ Sens Nrve Cndj Test	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Actigraphy Automated Point-of-Care Nerve Conduction Testing		
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Ambulatory or Video Electroencephalogram (EEG)	-	-
95954	Eeg Monitoring/Giving Drugs	predetermination to avoid post-service review.	MED205.008	Monitoring, Including Digital Analysis of Electroencephalogram Ambulatory or Video Electroencephalogram (EEG)	-	
95957	Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008 MED205.040	Monitoring, Including Digital Analysis of Electroencephalogram Quantitative Electroencephalography (QEEG) as a	_	_
		· · · · · · · · · · · · · · · · · · ·		Diagnostic Aid for Attention-Deficit Hyperactivity Disorder (ADHD) Intraoperative Neurophysiologic Monitoring (IONM)		
95961	Electrode Stimulation Brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009	Topographic Brain Mapping (Quantitative Electroencephalography)	-	6/30/2022
95962	Electrode Stim Brain Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Mapping (Quantitative Electroencephalography)	-	6/30/2022
95965	Meg Spontaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
95966	Meg Evoked Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
95967	Meg Evoked Each Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
95999	Neurological Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	- (WS)	_	_
96000	Motion Analysis Video/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.009	Gait Analysis	_	_
96001	Motion Test W/Ft Press Meas	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.009	Gait Analysis		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gait Analysis		
96002	Dynamic Surface Emg	predetermination to avoid post-service review.	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
96003	Dynamic Fine Wire Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	_	-
96004	Phys Review Of Motion Tests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009 MED205.006	Gait Analysis Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
96379	Ther/Prop/Diag Inj/Inf Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	=	-	-
96549	Chemotherapy Unspecified	Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
96912	Photochemotherapy With Uv-A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
96913	Photochemotherapy Uv-A Or B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions	_	-
96922	Laser Tx Skin >500 Sq Cm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Acne Management	_	
96931	Rcm Celulr Subcelulr Img Skn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033 MED201.023	Phototherapy for Dermatologic Conditions Optical Diagnostic Devices for Evaluating Skin Lesions		
96932		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Suspected of Malignancy Optical Diagnostic Devices for Evaluating Skin Lesions	_	
	Rcm Celulr Subcelulr Img Skn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Suspected of Malignancy Optical Diagnostic Devices for Evaluating Skin Lesions	_	_
96933	Rcm Celulr Subcelulr Img Skn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Suspected of Malignancy Optical Diagnostic Devices for Evaluating Skin Lesions		_
96934	Rcm Celulr Subcelulr Img Skn	predetermination to avoid post-service review.	MED201.023	Suspected of Malignancy	10/1/2021	_
96935	Rcm Celuir Subceluir Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	-	_
96936	Rcm Celuir Subceluir Img Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	_	_
96999	Dermatological Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
97024	Diathermy Eg Microwave	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.008 THE803.010 SUR705.010	Non-Covered Physical Therapy Services Physical Therapy (PT) and Occupational Therapy (OT) Services Temporomandibular Joint (TMJ) Disorders (TMJD)	-	6/30/2021
97039	Physical Therapy Treatment	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
97139	Physical Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
97169	Athletic Trn Eval Low Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
97170	Athletic Trn Eval Mod Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
97171	Athletic Trn Eval High Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_

97172	Athletic Trn Re-Eval Plan Cr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
5/1/2	Athletic Irn Re-Eval Plan Cr	service review.	- DCV204 044	- Autism Spectrum Disorders (ASD)	-	-
97533	Sensory Integration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.020	Sensory Integration Therapy and Auditory Integration Therapy	-	-
97537	Community/Work Reintegration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services	_	_
97610	Low Frequency Non-Thermal Us	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.044	Ultrasound Wound Therapy	_	-
97799	Physical Medicine Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
99024	Postop Follow-Up Visit	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	<u>-</u>	-		
99026	In-Hospital On Call Service	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	<u>-</u>	-	
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
99027	Out-Of-Hosp On Call Service	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
99050	Medical Services After Hrs	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
99056	Med Service Out Of Office	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
99058	Office Emergency Care	contract/clinical review.	-	-	_	-
99070	Special Supplies Phys/Qhp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
99071	Patient Education Materials	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
99078	Group Health Education	Unlisted: Procedure/service not specifically defined or classified Unlisted: Procedure/service not specifically defined or classified, may be subject to				
99078	Group Health Education	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
99080	Special Reports Or Forms	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
99082	Unusual Physician Travel	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
99192	Hunarharic Operan Theory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	PSY301.014	Autism Spectrum Disorders (ASD)		
99183	Hyperbaric Oxygen Therapy	require Prior Authorization per contract agreement.	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	-	-
99199	Special Service/Proc/Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
99360	Physician Standby Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
99429	Unlisted Preventive Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
99446	Ntrprof Ph1/Ntrnet/Ehr 5-10	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	1/1/2021	_
99447	Ntrprof Ph1/Ntrnet/Ehr 11-20	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	1/1/2021	_
99448	Ntrprof Ph1/Ntrnet/Ehr 21-30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	1/1/2021	_
99449	Ntrprof Ph1/Ntrnet/Ehr 31/>	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			1/1/2021	
99450	Basic Life Disability Exam	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
99451	Ntrprof Ph1/Ntrnet/Ehr 5/>	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			1/1/2021	
99452	Ntrprof Ph1/Ntrnet/Ehr Rfrl	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	1/1/2021	_
					1/1/2021	
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	1/1/2021	-
99453	Rem Mntr Physiol Param Setup	service review.	-	-	1/1/2021	-
99453 99454	Rem Mntr Physiol Param Setup Rem Mntr Physiol Param Dev	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	- -	- - -	1/1/2021 - -	-
99453 99454 99455	Rem Mntr Physiol Param Setup	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Not covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	- - -	- - -	- - -	- - -
99453 99454	Rem Mntr Physiol Param Setup Rem Mntr Physiol Param Dev Work Related Disability Exam Disability Examination	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	- - -	- - - -	1/1/2021 - - -	- - -
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99453 99454 99455 99456 99457 99491 99499 99600 0052U 0054T 0065U 0066U 0075T 0076T 0084U 0086U 0087U 0088U 0089U 0099U 0091U	Rem Mntr Physiol Param Setup Rem Mntr Physiol Param Dev Work Related Disability Exam Disability Examination Rem Physiol Mntr 1St 20 Min Chrnc Care Mgmt Svc 30 Min Unlisted E&M Service Home Visit Nos Lpoprtn Bid W/5 Maj Classes Bone Srgry Cmptr Fluor Image Bone Srgry Cmptr Fluor Image Al Sie Igg&igm Alys 80 Bmrk Neuro Autism 32 Amines Alg Pamg-1 Ia Cervico-Vag Fluid Perq Stent/Chest Vert Art S&I Stent/Chest Vert Art Bbc Dna Gnotyp 10 Bid Groups Nfct Ds Bact&Fng Orig Id 6+ Crd Hrt Trnspil Mnna 1283 Gen Trnspil Kdn Algft Rej 1494 Onc Minma Prame & Linc00518 Onc Cutan Minma Mrna 23 Gene Onc Circt Scr Whil Bid Alg	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Lill: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, 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 CPCPO8, 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 CPCPO8, 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 CPCPO8, 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 CPCPO8, 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 CPCPO8, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/servic	SUR705.023 SUR705.023 MED207.159 PSY301.014 OB401.018 SUR701.041	of Cardiovascular Disease Computer-Assisted Navigation for Orthopedic Procedures Computer-Assisted Navigation for Orthopedic Procedures Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases Autism Spectrum Disorders (ASD) Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy Endovascular Therapies for Extracranial Vertebral Artery Disease	-	
99453 99454 99455 99456 99457 99491 99600 0052U 0054T 0062U 0055T 0062U 0075T 0076T 0076T 0084U 0086U 0087U 0088U 0089U 0099U 0091U 0092U	Rem Mntr Physiol Param Setup Rem Mntr Physiol Param Dev Work Related Disability Exam Disability Examination Rem Physiol Mntr 1St 20 Min Chrnc Care Mgmt Svc 30 Min Unlisted E&M Service Home Visit Nos Lipoprtn Bid W/5 Maj Classes Bone Srgry Cmptr Fluor Image Bone Srgry Cmptr Fluor Image Bone Srgry Cmptr Fluor Image Ai Ste Igg&ligm Alys 80 Bmrk Neuro Autism 32 Amines Alg Pamg-1 la Cervico-Vag Fluid Perq Stent/Chest Vert Art S&I Stent/Chest Vert Art S&I Stent/Chest Vert Art This Dia Gnotyp 10 Bid Groups Nfct Ds Bact&Fng Org Id 6+ Crd Hrt Trnspl Mrna 1283 Gen Trnspli Kdn Algrit Rej 1494 Onc Minma Prame & Linc00518 Onc Cutan Minma Mrna 23 Gene Onc Circt Scr Whi Bid Alg Onc Ling 3 Prtn Bmrk Pism Alg	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject	SUR705.023 SUR705.023 MED207.159 PSY301.014 OB401.018 SUR701.041	of Cardiovascular Disease Computer-Assisted Navigation for Orthopedic Procedures Computer-Assisted Navigation for Orthopedic Procedures Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases Autism Spectrum Disorders (ASD) Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy Endovascular Therapies for Extracranial Vertebral Artery Disease	-	

		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0095U	Inflm Ee Elisa Alys Alg	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0096U	Hpv Hi Risk Types Male Urine	service review.	-	-	-	-
0097U	Gi Pathogen 22 Targets	Non Covered: Procedure/service may not covered by the Plan. Procedure/service reviewed against Medical Policy Criteria.	-	-	-	3/31/2022
0098U	Respir Pathogen 14 Targets	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	3/31/2021
0099U	Respir Pathogen 20 Targets	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	3/31/2021
0100T	Prosth Retina Receive&Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.026	Retinal Prosthesis		
		Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0100U	Respir Pathogen 20 Targets	service review.	-	-	-	3/31/2021
0101T	Extracorp Shockwy Tx Hi Enrg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.018	Extracorporeal Shock Wave Therapy for		
		Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified		Musculoskeletal Indications and Soft Tissue Injuries	-	_
0101U	Hered Colon Ca Do 15 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0102T	Extracorp Shockwy Tx Anesth	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.018	Extracorporeal Shock Wave Therapy for		
01021	Extracorp Shockwy 1x Ariestii	Policy (CPCP).	301703.016	Musculoskeletal Indications and Soft Tissue Injuries		_
0102U	Hered Brst Ca Rltd Do 17 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0103U	Hered Ova Ca Pnl 24 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0105U	Neph Ckd Mult Eclia Tum Nec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	_
0106T	Touch Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205 020	Quantitative Sensory Testing		
01001	Touch Quant Sensory Test	Policy (CPCP).	WED203.030	Quantitative sensory resumg	-	-
0106U	Gstr Emptg 7 Timed Brth Spec	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.017	Gastrointestinal (GI) Motility Measurement	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0107T	Vibrate Quant Sensory Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	-	-
0107U	C Diff Tox Ag Detcj la Stool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0108T	Cool Quant Sensory Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	-	-
0108U	Gi Barrett Esoph 9 Prtn Bmrk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	-	_
0109T	Heat Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.030	Quantitative Sensory Testing		
	,	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0109U	Id Aspergillus Dna 4 Species	service review.	-	-	-	-
0110T	Nos Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.030	Quantitative Sensory Testing	_	_
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0111U	Onc Colon Ca Kras&Nras Alys	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0112U	ladi 16S&18S Rrna Genes	service review.	-	-	-	-
0113U	Onc Prst8 Pca3&Tmprss2-Erg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0114U	Gi Barretts Esoph Vim&Ccna1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
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-	_	_	_	_
0117U	Pain Mgmt 11 Endogenous Anal	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_	_	_
0118U	Trnsplj Don-Drv Cll-Fr Dna	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
0119U		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
	Crd Ceramides Liq Chrom Plsm	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
0120U	Onc B Cll Lymphm Mrna 58 Gen	service review.	-	-	-	-
0121U	Sc Dis Vcam-1 Whole Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0122U	Sc Dis P-Selectin Whl Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
0123U	Mchnl Fragility Rbc Prflg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
0129U	Hered Brst Ca Ritd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
0130U	Hered Colon Ca Do Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	_
0131U	Hered Brst Ca Ritd Do Pnl 13	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0132U	Hered Ova Ca Ritd Do Pnl 17	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0133U	Hered Prst8 Ca Rltd Do 11	service review.	-	-	-	-
0134U	Hered Pan Ca Mrna Pnl 18 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0135U	Hered Gyn Ca Mrna Pnl 12 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
0136U	Atm Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
0137U	Palb2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0138U		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
01360	Brca1 Brca2 Mrna Seq Alys	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-	-	-
0139U	Neuro Austm Meas 6 C Metablt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	PSY301.014	Autism Spectrum Disorders (ASD)	-	9/30/2021
0140U	Nfct Ds Fungi Dna 15 Trgt	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
0141U	Nfct Ds Bact&Fng Gram Pos	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0141U		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
	Nfct Ds Bact&Fng Gram Neg	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
0143U	Drug Assay 120+ Rx/Metablt	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0144U	Drug Assay 160+ Rx/Metablt	service review.	-	-	-	-
0145U	Drug Assay 65+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-

		No. County December (see Section 2) and the Alexander (see Section 2)				
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-				
0150U	Drug Assay 120+ Rx/Metablt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0151U	Nfct Bct/Vir Resp Nfctj 33	service review.	-	-	_	3/31/2022
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.	-	-	-	-
0154U	Onc Urthl Ca Rna Fgfr3 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
0155U	Onc Brst Ca Dna Pik3Ca Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0156U	Copy Number Sequence Alys	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
0157U	Apc Mrna Seq Alys	service review.	-	-	-	-
0158U	Mlh1 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
0159U	Msh2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0160U	Msh6 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
0161U	Pms2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0162U		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Hered Colon Ca Trgt Mrna Pnl	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
0191T	Insert Ant Segment Drain Int	predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	5/1/2021	12/31/2021
0198T	Ocular Blood Flow Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.022	Ophthalmologic Techniques For Evaluating Glaucoma	-	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0202T	Post Vert Arthrplst 1 Lumbar	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.034	Facet Arthroplasty	-	-
0207T	Clear Eyelid Gland W/Heat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	OTH002 02E	Fuelid Thormal Dukation		
02071	Clear Eyelid Gland W/Heat	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	O1H903.025	Eyelid Thermal Pulsation	-	-
0219T	Plmt Post Facet Implt Cerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR712.032	Isolated Facet Joint Fusion	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0220T	Plmt Post Facet Implt Thor	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR712.032	Isolated Facet Joint Fusion	-	-
02247		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0221T	Plmt Post Facet Implt Lumb	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	-	-
02227		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0222T	Plmt Post Facet Implt Addl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR712.032	Isolated Facet Joint Fusion	_	_
02221	Plmt Post Facet Implt Addl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032		-	-
0232T 0232T	Plmt Post Facet Implt Addl Njx Platelet Plasma	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.101	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth	-	-
		review. Check EIU policy CPCP08, 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 CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma	-	-
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0317T	Elec Alys Vagus Nrv Pls Gen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	-
0330T	Tear Film Img Uni/Bi W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.025	Eyelid Thermal Pulsation	-	-
0331T	Heart Symp Image Plnr	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD604.012	Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure	4/1/2021	_
0335T	Insi Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.027	Subtalar Arthroereisis (STA)		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Radiofrequency Ablation of the Renal Sympathetic		
0338T	Trnscth Renal Symp Denry Unl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service	SUR701.030	Nerves as a Treatment for Resistant Hypertension	-	-
0339T	Trnscth Renal Symp Denry Bil	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0345T	TRANSCATH MTRAL VLVE REPAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.025	Transcatheter Mitral Valve Procedures	10/1/2022	_
0347T	Ins Bone Device For Rsa	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0348T	Rsa Spine Exam	Flui: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0349T	Rsa Upper Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0350T	Rsa Lower Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0352T	Oct Brst/Node I&R Per Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.053	Optical Coherence Tomography of the Breast	-	-
0354T	Oct Breast Surg Cavity I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.053	Optical Coherence Tomography of the Breast	_	-
0355T	Gi Tract Capsule Endoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	-	12/31/2021
0358T	Bia Whole Body	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RAD601.045	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance	_	_
0376T	Insert Ant Segment Drain Int	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Analysis (BIA) Aqueous Shunts and Stents for Glaucoma	_	12/31/2021
0378T	Visual Field Assmnt Rev/Rprt	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Home-Based Monitoring of Visual Field	-	-
0379Т	Vis Field Assmnt Tech Suppt	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.044	Home-Based Monitoring of Visual Field	-	-
0397T	Ercp W/Optical Endomicroscpy	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201 029	Confocal Laser Endomicroscopy (CLE)		
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Magnetic Resonance-Guided Focused Ultrasound	-	-
0398T 0402T	Mrgfus Strtctc Les Abltj Colgn Cross-Link Crn Med Sep	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	301701.022	(MRgFUS) Corneal Collagen Cross-Linking	-	6/30/2022
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Measurement of Phospholipase A2 in the Assessment		
0423T	Assay Secretory Type li Pla2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service	MED207.134	of Cardiovascular Risk	-	12/31/2021
0424T	Insj/Rplc Nstim Apnea Compl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0425T	Insj/Rplc Nstim Apnea Sen Ld	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0426T	Insj/Rplc Nstim Apnea Stm Ld	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0427T	Insj/Rplc Nstim Apnea Pls Gn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0428T	Rmvl Nstim Apnea Pls Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0429T	Rmvl Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0430T	Rmvl Nstim Apnea Stimj Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0431T	Rmvl/Rplc Nstim Apnea Pls Gn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0432T	Repos Nstim Apnea Stimj Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0433T	Repos Nstim Apnea Sensing Ld	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0434T	Interro Eval Npgs Apnea	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0435T	Prgrmg Eval Npgs Apnea 1 Ses	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0436T	Prgrmg Eval Npgs Apnea Study	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0444T	1St Plmt Drug Elut Oc Ins	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	_
0445T	Sbsqt Plmt Drug Elut Oc Ins	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	_
0449T	Insj Aqueous Drain Dev 1St	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma		
0450T	Insj Aqueous Drain Dev Each	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	_	_
0464T	Visual Ep Test For Glaucoma	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Visual Evoked Potential Testing for Glaucoma	-	_
0465T	Supchrdl Njx Rx W/O Supply	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Suprachoroidal Injection of a Pharmacologic Agent	_	9/14/2022
0465T	Supchrdl Njx Rx W/O Supply	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Suprachoroidal Injection of a Pharmacologic Agent	9/15/2022	
0466T	Insj Ch Wal Respir Eltrd/Ra	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Sleep Related Breathing Disorders: Surgical		12/31/2021
0470T	Oct Skn Img Acquisj I&R 1St	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Management Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	-
1		produces miniation to avoid post-service review.		Suspected of irrangifality		

0471T	Oct Skn Img Acquisj I&R Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	-
0472T	Prgrmg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	-	-
0473T	Reprgrmg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Palicy (CPCP)		Retinal Prosthesis	-	-
0474T	Insj Aqueous Drg Dev Io Rsvr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_
0479T	Fxjl Abl Lsr 1St 100 Sq Cm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cosmetic and Reconstructive Procedures	4/1/2021	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				_
0480T	Fxjl Abl Lsr Ea Addl 100Sqcm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	4/1/2021	_
0483T	Tmvi Percutaneous Approach	predetermination to avoid post-service review.	SUR707.025	Transcatheter Mitral Valve Procedures	10/1/2022	_
0484T	Tmvi Transthoracic Exposure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.025	Transcatheter Mitral Valve Procedures	10/1/2022	_
0485T	Oct Mid Ear I&R Unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	-	-
0486T	Oct Mid Ear I&R Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	-	-
0493T	Near Ifr Spectrsc Of Wounds	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.006	Foot Care Services	-	-
0499T	Cysto F/Urtl Strix/Stenosis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.026	Optilume (Drug Coated Balloon) for the Treatment of Urethral Stricture Conditions	-	-
0507T	Near Ifr 2Img Mibmn Glnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	-	-
0508T	Pls Echo Us B1 Dns Meas Tib	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.071	Pulse-Echo Ultrasound Bone Density Measurement	-	-
0509T	Pattern Erg W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	5/15/2021	-
0509T	Pattern Erg W/I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ОТН903.036	Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	2/15/2021	5/14/2021
0511T	Rmvl&Rinsj Sinus Tarsi Implt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	-	-
0512T	Esw Integ Wnd Hlg 1St Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0513T	Esw Integ Wnd HIg Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0524T	Ev Cath Dir Chem Abltj W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	4/1/2021	_
0533T	Cont Rec Mvmt Do 6-10 Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0534T	Cont Rec Mvmt Do Setup&Train	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0535T	Cont Rec Mvmt Do Reprt Cnfig	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0536T	Cont Rec Mvmt Do Dl W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0544T	TCAT MV ANNULUS RCNSTJ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.025	Baroreflex Stimulation Devices	10/1/2022	
OF 40T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0548T	Tprnl Balo Cntnc Dev Bi	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Implanted Adjustable Continence Therapy	-	12/31/2021
0549T	Tprnl Balo Cntnc Dev Uni	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Implanted Adjustable Continence Therapy	-	12/31/2021
0550T	Tprnl Balo Cntnc Dev Rmvl Ea	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Implanted Adjustable Continence Therapy	-	12/31/2021
0551T	Tprnl Balo Cntnc Dev Adjmt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Implanted Adjustable Continence Therapy Non-Reimbursable Experimental, Investigational	-	12/31/2021
0563T	Evac Meibomian Glnd Heat Bi	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	CPCP028	and/or Unproven Services (EIU)	-	-
0565T	Autol Cell Implt Adps Hrvg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) Othopadic Applications of Stem Cell Therapy	8/15/2021	-
0565T	Autol Cell Implt Adps Hrvg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow)	4/1/2021	8/14/2021
0566T	Autol Cell Implt Adps Njx	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	8/15/2021	-
0566T	Autol Cell Implt Adps Njx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow)	4/1/2021	8/14/2021
0587T	Perq Impltj/Rplcmt Isdns Ptn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	
0588T	Revision/Removal Isdns Ptn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	_
0589T	Elec Alys Smpl Prgrmg lins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	_
0590T	Elec Alys Cplx Prgrmg lins	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	
0602T	Transdermal Gfr Measurements	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Transdermal Glomerular Filtration Rate	4/1/2021	-
0603T	Transdermal Gfr Monitoring	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	-
0615T	Eye Mvmt Alys W/O Calbrj I&R	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
0620T	Evasc Ven Artiz Tibl/Prnl Vn	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0621T	Trabeculostomy Interno Laser	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Experimental, Investigational and/or Unproven	1/1/2021	_
		Policy (CPCP).		Procedures/Services		

		FILL December from the set of the least of the Alexandre New York Control of the State of the St				
0622T	Trabeculostomy Int Lsr W/Scp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven		
0623T	Auto Quantification C Plaque	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Procedures/Services	1/1/2021	-
0624T	Auto Quan C Plaq Data Prep	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven	1/1/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Procedures/Services	,,,	
0625T	Auto Quan C Plaq Cptr Alys	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven		
0626T	Auto Quan C Plaq I&R	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Procedures/Services	1/1/2021	-
0627T	Perq Njx Algc Fluor Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven		
0628T	Perq Njx Algc Fluor Lmbr Ea	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Procedures/Services	1/1/2021	-
0629T	Perq Nix Algc Ct Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001 032	Experimental, Investigational and/or Unproven	1/1/2021	
	Terq rija riige ee Eliioi 15e	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	7.511202.032	Procedures/Services	1/1/2021	-
0630T	Perq Njx Algc Ct Lmbr Ea	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven		
0631T	Tc Vis Lit Hyperspectral Img	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Procedures/Services	1/1/2021	-
0632T	Perg Tcat Us Ablti Nrv P-Art	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven	1/1/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Procedures/Services		
0639T	Wrls Skn Snr Anisotropy Meas	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
00.407		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven	-4-4	
0640T	Nente Nr Ifr Spetrse Wnd	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Procedures/Services	7/1/2021	-
0641T	Nente Nr Ifr Spetrse Wnd Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0642T	Nente Nr Ifr Spetrse Wnd I&R	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
0643T	Tcat L Ventr Rstrj Dev Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven	7/1/2021	_
0645T	Tcat Impltj C Sins Rdctj Dev	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Procedures/Services Experimental, Investigational and/or Unproven	7/1/2021	_
0646T	Ttvi/Rplcmt W/Prstc Vlv Perq	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Procedures/Services Experimental, Investigational and/or Unproven	7/1/2021	
	,	predetermination to avoid post-service review.		Procedures/Services Long-Term Ambulatory Cardiac Monitoring (Outpatient		
0650T	Prgrmg Dev Eval Scrms Remote	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection	7/1/2021	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Systems)		
0651T	MAG CTRLD CAPSULE ENDOSCOPY	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of Ti	1/1/2023	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon		42/24/2022
0651T	MAG CTRLD CAPSULE ENDOSCOPY	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Vertebral Body Stapling and Vertebral Body Tethering	11/1/2022	12/31/2022
0656T	Vrt Bdy Tethering Ant <7 Seg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.046	for the Treatment of Scoliosis	7/1/2021	-
0657T	Vrt Bdy Tethering Ant 8+ Seg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering	7/1/2021	_
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		for the Treatment of Scoliosis Optical Diagnostic Devices for Evaluating Skin Lesions		
0658T	Elec Impd Spectrsc 1+Skn Les	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.023	Suspected of Malignancy	10/1/2021	_
0664T	Don Hysterectomy Open Cdvr	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0664T	Don Hysterectomy Open Cdvr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		·		
0665T	Don Hysterectomy Open Liv	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0665T	Don Hysterectomy Open Liv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0666T	Don Hysterectomy Laps Liv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		<u> </u>		
0666T	Don Hysterectomy Laps Liv	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0667T	Don Hysterectomy Rcp Uter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	_
0667T	Don Hysterectomy Rcp Uter	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		·		
0668T	Bkbench Prep Don Uter Algrft	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0668T	Bkbench Prep Don Uter Algrft	ASD Coloredo December Association of control and control and colored Association Delica Coloredo Color	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0669T	Bkbench Rcnstj Don Uter Ven	EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	
	· ·	Policy (PCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				-
0669T	Bkbench Rcnstj Don Uter Ven	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0670T	Bkbench Rcnstj Don Uter Artl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	_
0670T	Bkbench Rcnstj Don Uter Artl	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
	and a second control of the second con	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			., .,	-, 1-7, 2021
0672T	NDOVAG CRYG RF REMDL TISS	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	1/1/2023	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	12/1/2022	12/31/2022
0672T	NDOVAG CRYG RE PEMPI TIES	predetermination to avoid post-service review				12/31/2022
0672T	NDOVAG CRYG RF REMDL TISS Ambulance Service Advanced Life	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Andrews and Trans. 12 1	2044.00.45	
0672T A0426		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Transport Services	2014-09-15	-
	Ambulance Service Advanced Life Support Non-Emergency Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.		Ambulance and Transport Services Ambulance and Medical Transport Services	2014-09-15	- -
A0426	Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (Als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	ADM1001.005	·	2014-09-15	- -
A0426 A0430	Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (Als 1) Fixed Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may regulare Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	ADM1001.005 ADM1001.005	Ambulance and Medical Transport Services	2014-09-15	- - -
A0426 A0430 A0431	Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (lab.1) Fixed Wing Air Transport Rotary Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005 ADM1001.005 ADM1001.005	Ambulance and Medical Transport Services Ambulance and Medical Transport Services	2014-09-15	-

		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
A0888	Noncovered Ambulance Mileage	predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	-	_
A0999	Unlisted Ambulance Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
A2001	Innovamatrix Ac Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-15	-
A2002	Mirragen adv wnd mat per sq	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	_
A2002	Mirragan adv wnd mat ner co	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUP704 012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2004	Mirragen adv wnd mat per sq Xcellistem per sq cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022	4/14/2022
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			7-37-3	
A2004	Xcellistem per sq cm	predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2005	Microlyte matrix per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2005	Microlyte matrix per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2006	Novosorb synpath per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2006	Novosorb synpath per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2007	Restrata per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2007	Restrata per sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704 012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
712007	nestrata per sq ciri	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	301704.012	bioengineered 3xiii and 3oft 1153de 3do3titutes	1/13/2022	4/14/2022
A2008	Theragenesis per sq cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2008	Theragenesis per sq cm	predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2009	Symphony per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2009	Symphony per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2010	Apis per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	4/15/2022	-
A2010	Apis per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	4/14/2022
A2011	Supra Sdrm Per Sq Cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	N/A	N/A	4/1/2022	-
A2012	Suprathel Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	N/A	N/A	4/1/2022	_
A2013	Innovamatrix Fs Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	N/A	N/A	4/1/2022	_
A2014		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	
	Omeza collag per 100 mg	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
A2014	Omeza collag per 100 mg	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/1/2022	3/31/2023
A2015	Phoenix wnd mtrx per sq cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	
A2015	Phoenix wnd mtrx per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/1/2022	3/31/2023
A2016	Permeaderm b per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	
A2016	Permeaderm b per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/1/2022	3/31/2023
A2017	Permeaderm glove each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	
A2017	Permeaderm glove each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/1/2022	3/31/2023
A2018		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2023	
A2018	Permeaderm c per sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/1/2022	3/31/2023
A4100	Permeaderm c per sq cm Skin Sub Fda Clrd As Dev Nos	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		N/A	4/1/2022	3/31/2023
A4267		Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				12/21/2022
	Male Condom	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	-	-	-	12/31/2022
A4290	Sacral Nerve Stim Test Lead	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	-	10/1/2022
A4335	Incontinence Supply	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
A4421	Ostomy Supply Misc	contract/clinical review.	-	-	-	-
A4458	Reusable Enema Bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
A4520	Incontinence Garment Anytype	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
A4553	Nondisp Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
A4554	Disposable Underpads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
A4555	Ca Tx E-Stim Electr/Transduc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	-	-
A4575	Hyperbaric O2 Chamber Disps	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	PSY301.014 THE801.003	Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy	-	-
A4596	Ces system monthly supp	Policy (CPCP). PA maybe required until 04/01/2022. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding			4/1/2023	
A4596	Ces system monthly supp	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.019 SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electro Cranial Electrotherapy Stimulation and Auricular Electro		3/31/2023
A4600	Sleeve Inter Limb Comp Dev	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	-	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Venous Thromboembolism Prophylaxis		
A4639	Infrared Ht Sys Replcmnt Pad	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	-	-
A4641	Radiopharm Dx Agent Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_

A4649	Surgical Supplies	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
A4890	Repair/Maint Cont Hemo Equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
A4913	Misc Dialysis Supplies Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_	-
A4927	Non-Sterile Gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
A4931	Reusable Oral Thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	_	_	_
A4932	Reusable Rectal Thermometer	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
A5507	Modification Diabetic Shoe	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Modification Statetic State	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-		
A6000	Wound Warming Wound Cover	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
A6261	Wound Filler Gel/Paste /Oz	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_	_
A6262	Wound Filler Dry Form / Gram	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
A6512	Compres Burn Garment Noc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
A6549		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	<u>-</u>	_	
	G Compression Stocking	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
A9150	Misc/Exper Non-Prescript Dru	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
A9152	Single Vitamin Nos	service review.	-	-	-	_
		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
A9153	Multi-Vitamin Nos	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
A9273	Hot/Cold Botle/Cap/Col/Wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	_	_	_
A9279	Monitoring Feature/Devicenoc	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
A9280	Alert Device Noc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	Upper-Limb Prosthesis, Including Myoelectric and	-	
A9282	Wig Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	6/30/2022
A9282	Wig any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.			7/1/2022	
A3202	wig any type	Unlisted: Procedure/service not specifically defined or classified	-	-	7/1/2022	-
A9285	Inversion Eversion Cor Devic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME103.001	Orthotics	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
A9291	Pres Digital Behav Thera Fda	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY302.002	Digital Health Therapies for Substance Abuse	2022-04-01	-
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
A9515	Choline C-11	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	
A9579	Gad-Base Mr Contrast Nos 1MI	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		·		
A9597	Pet Dx For Tumor Id Noc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	<u>-</u>	<u>-</u>		
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	_
A9598	Pet Dx For Non-Tumor Id Noc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
A9698	Non-Rad Contrast Materialnoc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
A9699	Radiopharm Rx Agent Noc	contract/clinical review.	-	-	-	-
A9900	Supply/Accessory/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
A9999	Dme Supply Or Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
B4105	Enzyme Cartridge Enteral Nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.011	Nutritional Support	_	6/30/2022
B9998	Enteral Supp Not Otherwise C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_	_
B9999	Parenteral Supp Not Othrws C	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
		contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental, Investigational and/or Unproven		
C1052	Hemostatic Agent Gi Topic	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Procedures/Services	5/15/2021	-
C1052	Hemostatic Agent Gi Topic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Experimental, Investigational and/or Unproven Procedures/Services	2/1/2021	5/14/2021
C1761	Cath Trans Intra Litho/Coro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven	2021-07-01	_
		predetermination to avoid post-service review.		Procedures/Services Long-Term Ambulatory Cardiac Monitoring (Outpatient		
C1764	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection	_	-
			CLIP705 024	Systems) Total Ankle Replacement (TAR)		
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.024	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	-	-
	Onderland American Broke Br	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_
C1783	Ocular Imp Aqueous Drain De					
	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Keratoprosthesis	_	
C1818	Integrated Keratoprosthesis	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	OTH903.030		_	-
C1818		predetermination to avoid post-service review. MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.030 SUR701.042	Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	<u>-</u>
C1818	Integrated Keratoprosthesis	predetermination to avoid post-service review. MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPDs, which is one of our Clinical Payment and Coding Policy (CPCP). MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030 SUR701.042		- 4/1/2022 2/1/2021	-
C1818 C1823 C1825	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro	predetermination to avoid post-service review. MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell:Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPD, which is one of our Clinical Payment and Coding Policy (CPCP). MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.030 SUR701.042 THE801.034	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient	2/1/2021	-
C1818 C1823 C1825	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim	predetermination to avoid post-service review. MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPDs, which is one of our Clinical Payment and Coding Policy (CPCP). MP Critteria. Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030 SUR701.042 THE801.034	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection		- -
C1818 C1823 C1825 C1833	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro	predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	OTH903.030 SUR701.042 THE801.034 MED202.003	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event	2/1/2021	-
C1783 C1818 C1823 C1825 C1825 C1833 C1841	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro	predetermination to avoid post-service review. MP Critteria : Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli:Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPOB, which is one of our Clinical Payment and Coding Policy (CPCP). MP Critteria:Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.030 SUR701.042 THE801.034 MED202.003	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection	2/1/2021	-
C1818 C1823 C1825 C1833 C1841	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp	predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EILI policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EILI policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	-
C1818 C1823 C1825 C1833 C1841	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys	predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, 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 CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and intracardiac ischemia Detection Systems)	2/1/2021	- - - -
C1818 C1823 C1825 C1833 C1841 C1842	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPD8, 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 CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis Retinal Prosthesis	2/1/2021	-
C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc	predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EILI policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EILI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis Retinal Prosthesis Endovascular Therapies for Extracranial Vertebral Artery Disease	2/1/2021	-
C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On	predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Critteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, 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 CPCP08, 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 CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unitstee: Procedure/service not specifically defined or classified, may be subject to	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 -	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - 6/30/2022
C1818 C1823 C1825 C1833 C1841 C1842	Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, 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 CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Contract/clinical review.	OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR701.041 SUR701.028	Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis Retinal Prosthesis Endovascular Therapies for Extracranial Vertebral Artery Disease	2/1/2021	- - - - - - 6/30/2022

C2600	Described Community	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
C2698	Brachytx Stranded Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
C2699	Brachytx Non-Stranded Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
C9072	Inj Imm Glob Asceniv	predetermination to avoid post-service review.	#N/A	#N/A	2/1/2021	3/31/2021
C9073	Brexucabtagene Autoleucel Ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	2/1/2021	3/31/2021
C9074	Injection Lumasiran	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/1/2021	6/30/2021
C9081	Idecabtagene car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	10/1/2021	12/31/2021
C9085	Inj Avalglucosid Alfa-Ngpt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	1/1/2022	3/31/2022
C9092	Inj. Xipere 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.035	Suprachoroidal Injection of a Pharmacologic Agent	2022-04-01	6/30/2022
C9093	Inj. Susvimo 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	2022-04-01	6/30/2022
C9094	Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.087	FDA-Approved Drugs and Biologicals	7/1/2022	9/30/2022
C9097	Inj faricimab-svoa 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.044	Faricimab-svoa	7/1/2022	9/30/2022
C9098	C'lla la	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	10/1/2022	9/30/2022
	Ciltacabtagene car pos t	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	OTH903.020	Bevacizumab for Ophthalmological Indications	10/1/2022	
C9257	Bevacizumab Injection	require Prior Authorization per contract agreement.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	-	-
C9354	Veritas Collagen Matrix Cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9356	Tenoglide Tendon Prot Cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9358	Dermal Substitute Native Non- Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9359	Implnt,bon void filler-putty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used	4/1/2021	_
C9360	Surgimend Neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	With Autologous Bone Marrow) Bioengineered Skin and Soft Tissue Substitutes		
		Policy (CPCP).		Orthopedic Applications of Stem Cell Therapy		_
C9362	Implnt,bon void filler-strip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR703.051	(Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	4/1/2021	-
C9363	Integra Meshed Bil Wound Mat	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
C9364	Porcine Implant Permacol	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes Casimersen	-	-
C9399	Unclassified Drugs Or Biologicals	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.135 RX501.067 RX501.067 RX501.087 RX504.003 RX501.139 RX501.130 RX501.129	Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders FDA-Approved Drugs and Biologicals Immunegiobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Rethymic Veklury Viltolarsen	-	-
C9739	Cystoscopy Prostatic Imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.023	Prostatic Urethral Lift	_	_
C9740	Cysto Impl 4 Or More	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.023	Prostatic Urethral Lift		
C9757	Spine/Lumbar Disk Surgery	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Annulus Closure After Discectomy	2022-08-01	-
C9757	Spine/Lumbar Disk Surgery	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.045	Annulus Closure After Discectomy	2022-05-01	2022-07-31
C9764	Revasc intravasc lithotripsy	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Experimental, Investigational and/or Unproven	5/15/2021	
C9765	Revasc intra lithotrip-stent	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Procedures/Services Experimental, Investigational and/or Unproven	5/15/2021	
C9766		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Procedures/Services Experimental, Investigational and/or Unproven		_
	Revasc intra lithotrip-ather	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Procedures/Services Experimental, Investigational and/or Unproven	5/15/2021	-
C9767	Revasc lithotrip-stent-ather	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Procedures/Services	5/15/2021	-
C9768	Endo Us-Guide Hep Porto Grad	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	3/1/2021	-
C9769	Cysto W/Temp Pros Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Temporary Prostatic Stent	-	
C9770	Vitrectomy, Mechanical, Pars Plana Approach, With Subretinal Injection Of Pharmacologic/Biologic Agent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	4/1/2021	-
C9771	NsI/Sins Cryo Post Nasal Tis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Nasal and Sinus Surgery	5/15/2021	-
C9771	NsI/Sins Cryo Post Nasal Tis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.001	Nasal and Sinus Surgery	2/1/2021	5/14/2021
C9772	Revasc lithotrip tibi/perone	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9772	Revasc lithotrip tibi/perone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9773	Revasc lithotr-stent tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Paline (CCD).		Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9773	Revasc lithotr-stent tib/per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9774	Revasc lithotr-ather tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPC).		Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9774	Revasc lithotr-ather tib/per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9775	Revasc lith-sten-ath tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Procedures/Services Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9775	Revasc lith-sten-ath tib/per	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven	5/15/2021	8/14/2021
C9777	Esophag Mucosal Integ Add-On	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Procedures/Services EIU Procedures/Services	8/15/2021	-
C9898	Inpnt Stay Radiolabeled Item	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
C9899	Inpt Implant Pros Dev No Cov	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-

D0999	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D1705	AstraZeneca Covid-19 vaccine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			3/15/2021	
D1703	administration first dose	service review.	-	-	3/15/2021	-
D1706	AstraZeneca Covid-19 vaccine administration second dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	3/15/2021	-
D1999	Unspecified Preventive Procedure By	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Report Unspecified Restorative Procedure By	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
D2999	Report Restorative Procedure By	contract/clinical review.	-	-	-	-
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Unspecified Endodontic Procedure By	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
D3999	Report	contract/clinical review.	-	-	-	-
D4999	Unspecified Periodontal Procedure By	Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
	Report Unspecified Removable Prosthodontic	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
D5899	Procedure By Report	contract/clinical review.	-	-	-	-
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
D6199	Unspecified Implant Procedure By	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
50133	Report	contract/clinical review.	-	-	-	-
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
	Extraction Erupted Tooth Requiring	CONTRACT CALCAS.				
D7210		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	_
	Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	service review.				
D7220	Removal Of Impacted Tooth - Soft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Tissue Removal Of Impacted Tooth - Partially	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
D7230	Bony	service review.	-	-	-	-
D7999		Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
D0346	Report	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
D8210	Removable Appliance Therapy	service review.	-	-	-	-
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
D8999	Unspecified Orthodontic Procedure By					
20333	Report	contract/clinical review.	-	-	-	-
D9999	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0183	Press underlay alter w/pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Hospital Beds and Related Equipment	10/1/2022	
	Tress andertay area wy pump	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	MED205.030	Quantitative Sensory Testing	10/1/2022	
E0210	Electric Heat Pad Standard	service review.	-	-	_	-
E0217	Water Circ Heat Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	· · · · · · · · · · · · · · · · · · ·	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
E0218	Fluid Circ Cold Pad W Pump	service review.	-	-	-	-
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101 045	Chin Contact Manachromatic Infrared Energy (MIDE)		
L0221	illiared neating rad system	Policy (CPCP).	DIVIE101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
E0231	Wound Warming Device	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
E0232	Warming Card For Nwt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0236	Duran Fara Water Class Justine D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
EU230	Pump For Water Circulating P	service review.	-	-	-	-
E0240	Bath/Shower Chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
E0241	Bath Tub Wall Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
LU241	Datii i ub Wali Kali	service review.	-	-	-	-
E0242	Bath Tub Rail Floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
E0243	Toilet Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
E0244	Toilet Seat Raised	service review.	-	-	-	-
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
E0246	Transfer Tub Rail Attachment	service review.	-	-	-	-
E0247	Trans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	_
50246		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
EU248	Hdtrans Bench W/Wo Comm Open	service review.	-	-	-	-
E0273	Bed Board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
E0274	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Over-bed Table	Service review. MR Criteria: Procedure/conice reviewed against Medical Policy Criteria: Submit for	-	-	-	-
E0300	Enclosed Ped Crib Hosp Grade	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	-	_
E0315	Bed Accessory Brd/Tbl/Supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
E0316	Bed Safety Enclosure	predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment		
E0446	Topical Ox Deliver Sys Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
E0471	Rad W/Backup Non Inv Intrfc	require Prior Authorization per contract agreement.	MED204.005	Diagnosis and Medical Management of Sleep Related B	r Moved to PA list	6/30/2021
E0485	Oral Device/Appliance Prefab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	MED204.005	Diagnosis and Medical Management of Sleep Related	_	_
E0486		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	MED204 00F	Breathing Disorders Diagnosis and Medical Management of Sleep Related		
20400	Oral Device/Appliance Cusfab	require Prior Authorization per contract agreement.	MED204.005	Breathing Disorders	-	-
E0487	Electronic Spirometer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.040	Home Spirometry		
		Policy (CPCP).			_	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Long-Term Ambulatory Cardiac Monitoring (Outpatient		
E0616	Cardiac Event Recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection	-	-
				Systems)		
E0625	Patient Lift Bathroom Or Toi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
E0635	Patient Lift Electric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF101 034	Lifts, Elevators, and Standing Frames/Systems		
20033	, scient and piettift	predetermination to avoid post-service review.	S.VIC.101.034	and, dievators, and standing reames/systems	-	_
E0637	Combination Sit To Stand Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0638	Standing Frame Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E0641	Multi-Position Stnd Fram Sys	predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	_
E0642	Dynamic Standing Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.034	Lifts, Elevators, and Standing Frames/Systems	_	_
		predetermination to avoid post-service review.				

E0650	Pneuma Compresor Non-Segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	_	_
				Venous Thromboembolism Prophylaxis		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0651	Pneum Compressor Segmental	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0652	Danim Compres M/Col Brossure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Lymphedema and Venous Ulcers		
20032	Pneum Compres W/Cal Pressure	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0655	Pneumatic Appliance Half Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lymphedema and Venous Ulcers		
		predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
				Pneumatic Compression Pumps for Treatment of		
E0656	Segmental Pneumatic Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	_	_
		predetermination to droid post service review.	WEDEDE.O/J	Venous Thromboembolism Prophylaxis		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0657	Segmental Pneumatic Chest	predetermination to avoid post-service review.	MED202.003	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0660	Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Lymphedema and Venous Ulcers		
20000	Pheumatic Appliance Full Leg	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0665	Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lymphedema and Venous Ulcers		
		predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
				Pneumatic Compression Pumps for Treatment of		
E0666	Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060 MED202.073	Lymphedema and Venous Ulcers	_	_
		predetermination to avoid post-service review.		Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis		
		MD Criteria: Procedure/consider reviewed against Medical Bollow Criteria: Cuberta Control	MED202 060	Pneumatic Compression Pumps for Treatment of		
E0667	Seg Pneumatic Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0668	Seg Pneumatic Appl Full Arm	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis		
E0669	Sag Dnaumatic Appli Half :	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0009	Seg Pneumatic Appli Half Leg	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0670	Seg Pneum Int Legs/Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lymphedema and Venous Ulcers		
20070	Seg Friedin int Legs/Trunk	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0671	Pressure Pneum Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lymphedema and Venous Ulcers	_	_
		predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis		
				Pneumatic Compression Pumps for Treatment of		
E0672	Pressure Pneum Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	_	_
		predetermination to avoid post-service review.	WIED202.073	Venous Thromboembolism Prophylaxis		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of		
E0673	Pressure Pneum Appl Half Leg	predetermination to avoid post-service reviewe.	MED202.060 MED202.073	Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for	-	-
				Venous Thromboembolism Prophylaxis		
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0675	Pneumatic Compression Device	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.073	Postsurgical Outpatient Use of Limb Compression	-	-
				Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of		
E0676	Inter Limb Compress Dev Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	MED202.060	Lymphedema and Venous Ulcers		
20070	inter clinib compress bev Nos	contract/clinical review.	MED202.073	Postsurgical Use of Limb Compression Devices for	-	-
E0691	11-12-12-5-5-0-1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THF801.033	Venous Thromboembolism Prophylaxis		
E0091	Uvl Pnl 2 Sq Ft Or Less	predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	_
E0692	Uvi Sys Panel 4 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
E0693	Uvi Sys Panel 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
E0694	Uvl Md Cabinet Sys 6 Ft	predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	_	-
E0731	Conductive Garment For Tens/	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.040	Transcutaneous Electrical Stimulation (TENS) and		6/20/2022
LU/31	conductive Garment For Tens/	predetermination to avoid post-service review.	WED201.040	Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)		6/30/2022
E0740	New Joseph Dalv Pl. S. St.	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME101.037	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary		
E0740	Non-Implant Pelv Flr E-Stim	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.030	or Fecal Incontinence Sexual Dysfunctions, Assessment and Treatment	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR710.018	Sacral Nerve Neuromodulation/Stimulation		
E0745	Neuromuscular Stim For Shock	require Prior Authorization per contract agreement.	MED201.026	Surface Electrical Stimulation	-	10/1/2022
E0747	Elec Osteogen Stim Not Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.044	Electrical Bone Growth Stimulation of the Appendicular		
-0.4/	and osteogen still Not Spine	predetermination to avoid post-service review.	354703.044	Skeleton	_	-
E0748	Elec Osteogen Stim Spinal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.013	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	-	_
				Electrical Bone Growth Stimulation of the Appendicular		
E0749	Elec Osteogen Stim Implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.044 SUR705.013	Skeleton Flectrical Stimulation of the Spine as an Adjunct to	-	_
		require Prior Authorization per contract agreement.	55.1705.015	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures		
E0760	Osteogen Ultrasound Stimltor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.030	Low Intensity Pulsed Ultrasound Fracture Healing	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Device Electrostimulation and Electromagnetic Therapy for		
E0761	Nontherm Electromgntc Device	predetermination to avoid post-service review.	MED201.027	Treating Wounds	-	-
E0762	Trans Elec Jt Stim Dev Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.042	Electrical Stimulation for the Treatment of Arthritis		
	Secon Sum Sev sys	Policy (CPCP).		Treatment of Arthritis	-	-
E0764	Functional Neuromuscularstim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201 033	Functional Neuromuscular Electrical Stimulation		6/30/2021
_0.04	. anctional Neuroniuscularstim	Policy (CPCP).		. acaonar ivearonidscular electrical stimulation	-	5, 30, 2021
E0764	Cunstional Na	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201 022	Functional Neuromy	4/1/2022	
20704	Functional Neuromuscularstim	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	WILD201.055	Functional Neuromuscular Electrical Stimulation	4/1/2022	-
E0764	Functional Neuromuscularstim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.033	Functional Neuromuscular Electrical Stimulation	1/1/2022	3/31/2022
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
E0766	Elec Stim Cancer Treatment	predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Electrostimulation and Electromagnetic Therapy for		
E0769	Electric Wound Treatment Dev	Policy (CPCP).	MED201.027	Treating Wounds	-	-
		Unlisted: Procedure/service not specifically defined or classified				

E0770	Functional Electric Stim Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.033	Functional Neuromuscular Electrical Stimulation	-	-
E0830	Ambulatory Traction Device	EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, which is one of our Clinical Payment and Coding	DME101.041	Pneumatic Traction and Spinal Unloading Devices	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
E0840	Tract Frame Attach Headboard	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Traction Devices for Use in the Home	-	-
E0849	Cervical Pneum Trac Equip	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	-	-
E0850	Traction Stand Free Standing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.046	Traction Devices for Use in the Home	_	_
E0855	Cervical Traction Equipment	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.046	Traction Devices for Use in the Home		
20033	cervical fraction Equipment	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
E0856	Cervic Collar W Air Bladders	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	-	-
E0860	Tract Equip Cervical Tract	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	_	-
E0890	Traction Frame Attach Pelvic	FUIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.046	Traction Devices for Use in the Home	_	_
E0935	Cont Pas Motion Exercise Dev	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.023	Continuous Passive Motion (CPM) Device		6/30/2022
E0936	Cpm Device Other Than Knee	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Continuous Passive Motion (CPM) Device		4.4
20330	cpin bevice other man knee	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DIVICIOI.023	Continuous Passive Motion (CPM) Device	-	-
E0942	Cervical Head Harness/Halter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0985	W/C Seat Lift Mechanism	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E0986	Man W/C Push-Rim Powr System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1002	Pwr Seat Tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1003	Pwr Seat Recline	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1004		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010			
	Pwr Seat Recline Mech	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	_	
E1005	Pwr Seat Recline Pwr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E1006	Pwr Seat Combo W/O Shear	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1007	Pwr Seat Combo W/Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1008	Pwr Seat Combo Pwr Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1009	Add Mech Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1010	Add Pwr Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1012	Ctr Mount Pwr Elev Leg Rest	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1161	Manual Adult Wc W Tiltinspac	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	DIVILIOI.010	wifeerings and Accessories	-	_
E1229	Pediatric Wheelchair Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
E1230	Power Operated Vehicle	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.	DME101.010	Wheelchairs and Accessories	-	_
E1239	Ped Power Wheelchair Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	-	-
E1399	Durable Medical Equipment Mi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E1629	Tablo For Dialysis Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE802.002	Daily Hemodialysis and Hemodialysis in the Home	2022-01-01	_
E1632	Wearable artificial kidney	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE802.002	Daily Hemodialysis and Hemodialysis in the Home	1/1/2023	
E1632	Wearable artificial kidney	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE802.002	Setting Daily Hemodialysis and Hemodialysis in the Home	7/1/2022	12/31/2022
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	THE802.002	Setting	7/1/2022	12/31/2022
E1699	Dialysis Equipment Noc	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-	-	_
E1700	Jaw Motion Rehab System	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1701	Repl Cushions For Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1702	Repl Measr Scales Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1902	Aac Non-Electronic Board	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid nost-service review.	PSY301.014 DME104.009	Autism Spectrum Disorders (ASD)	_	12/31/2021
E2300	Pwr Seat Elevation Sys	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for sealth continuous and post-service review.	DME101.010	Speech Generating Devices (SGD) Wheelchairs and Accessories	_	_
E2301	Pwr Standing	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2310	Electro Connect Btw Control	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2311	Electro Connect Btw 2 Svs	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories Wheelchairs and Accessories	_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
E2312	Mini-Prop Remote Joystick	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2313	Pwc Harness Expand Control	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2321	Hand Interface Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2322	Mult Mech Switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories		
E2323	Special Joystick Handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2324	Chin Cup Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2325	Sip And Puff Interface	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2326	Breath Tube Kit	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2327	Head Control Interface Mech	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review.			-	-

E2328	Head/Extremity Control Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2329	Head Control Nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2330	Head Control Proximity Switc	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2331		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
	Attendant Control	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2340	W/C Wdth 20-23 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2341	W/C Wdth 24-27 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2342	W/C Dpth 20-21 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2343	W/C Dpth 22-25 In Seat Frame	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2351		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010		-	
	Electronic Sgd Interface	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	
E2373	Hand/Chin Ctrl Spec Joystick	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2374	Hand/Chin Ctrl Std Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2375	Non-Expandable Controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2376	Expandable Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2377	Expandable Controller Initl	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E2500	Sgd Digitized Pre-Rec <=8Min	predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	_
E2502	Sgd Prerec Msg >8Min <=20Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2504	Sgd Prerec Msg>20Min <=40Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2506	Sgd Prerec Msg > 40 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	
E2508	Sgd Spelling Phys Contact	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E2510	Sgd W Multi Methods Msg/Accs	predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	_
E2511	Sgd Sftwre Prgrm For Pc/Pda	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2512	Sgd Accessory Mounting Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2599	C-d AN	MP Criteria: Procedure/service reviewed against Medical Criteria.	DMF404.000	County County During (CCD)		
E2399	Sgd Accessory Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2610	Powered W/C Cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
G0176	Opps/Php;Activity Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)	_	_
G0235	Pet Imaging Any Site Not Otherwise	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	ΔIM	AIM Guidelines		
	Specified	contract/clinical review. May require PA per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
G0255	Current Percep Threshold Tst	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.033 MED205.030	Automated Point-of-Care Nerve Conduction Testing Quantitative Sensory Testing	-	_
G0276	Pild/Placebo Control Clin Tr	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	They hace be control chirt	service review.	-	-	-	-
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Electrostimulation and Electromagnetic Therapy for		
G0281	Elec Stim Unattend For Press	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Treating Wounds	-	-
G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201 027	Electrostimulation and Electromagnetic Therapy for		
00202	Liect Still Would Care Not Fu	Policy (CPCP).	WED201.027	Treating Wounds	-	-
G0293	Non-Cov Surg Proc Clin Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G0294	Non-Cov Proc Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.027	Electrostimulation and Electromagnetic Therapy for		
G0295	Electromagnetic Therapy Onc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.008	Treating Wounds Non-Covered Physical Therapy Services	-	-
G0329	Electromagntic Tx For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds		
	Electroning interview of electronic	Policy (CPCP).	THE803.008	Non-Covered Physical Therapy Services	-	-
G0341	Percutaneous Islet Celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_
G0342	Laparoscopy Islet Cell Trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_
G0343	Laparotomy Islet Cell Transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Saturation Biopsy for Diagnosis, Staging and		
G0416	Prostate Biopsy Any Mthd	predetermination to avoid post-service review.	SUR717.015	Management of Prostate Cancer, Including Comprehensive 3D Mapping with Biopsy	-	6/30/2022
G0422	Intens Cardiac Rehab W/Exerc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.023	Cardiac Rehabilitation (CR)	_	
G0423	Intens Cardiac Rehab No Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cardiac Rehabilitation (CR)		
	Collagen Meniscus Implant Procedure	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
G0428	For Filling Meniscal Defects (E.G. Cmi	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.034	Meniscal Allografts and Other Meniscal Implants	-	-
	Collagen Scaffold Menaflex) Dermal Filler Injection(S) For The	Policy (CPCP). PA maybe required until 04/01/2022.				
G0429	Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
	Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
G0455	Fecal Microbiota Prep Instil	predetermination to avoid post-service review.	SUR703.049	Fecal Microbiota Transplantation (FMT)	-	6/30/2022
G0460	Autologous Prp For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Conditions Recombinant and Autologous Platelet-Derived Growth		
G0465	Autolog Prp Diab Wound Ulcer	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.034	Factors for Wound Healing and Other Non-Orthopedic		_
		Policy (CPCP). MB Criteria: Procedure (service reviewed against Modical Policy Criteria, Submit for		Conditions Recombinant and Autologous Platelet-Derived Growth		
G0465	Autolog Prp Diab Wound Ulcer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.034	Factors for Wound Healing and Other Non-Orthopedic Conditions	4/13/2021	3/31/2022
G2011	Alcohol/Sub Misuse Assess	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		Condition		
		service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	BYE01 105	Esketomine Nasal Saray	-	4/15/2021
G2082	Visit Esketamine 56M Or Less	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray		4/15/2021
G2082	Visit esketamine 56m or less	predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	08/01/2021	
G2083	Visit Esketamine > 56M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	-	4/15/2021
G2083	Visit esketamine > 56m	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray	08/01/2021	-
G2083 G8395	Visit esketamine > 56m Lvef>=40% Doc Normal Or Mild		RX501.105	Esketamine Nasal Spray	08/01/2021	_

G8396	Lvef Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G8397	Dil Macula/Fundus Exam/W Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8399	Pt W/Dxa Results Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
G8400	Pt W/Dxa No Results Doc	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G8404	Low Externity Neur Exam Docum	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8405	Low Externity Neur Not Perfor	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8410	Eval On Foot Documented	service review.	-	-	-	-
G8415	Eval On Foot Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8416	Pt Inelig Footwear Evaluatio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G8417	Calc Bmi Abv Up Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8418	Calc Bmi Blw Low Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G8419	Calc Bmi Out Nrm Param Nof/U	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G8420	Calc Bmi Norm Parameters	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8421		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	<u>-</u>	-	-
	Bmi Not Calculated	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8422	Pt Inelig Bmi Calculation	service review.	-	-	-	12/31/2021
G8427	Docrev Cur Meds By Elig Clin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8428	Cur Meds Not Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G8430	Doc Med Rsn No Medrec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8431	Pos Clin Depres Scrn F/U Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
G8432	Dep Scr Not Doc Rng	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G8433	Scr For Dep Not Cpt Doc Rsn	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8450	Beta-Bloc Rx Pt W/Abn Lvef	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8451	Pt W/Abn Lvef Inelig B-Bloc	service review.	-	-	-	-
G8452	Pt W/Abn Lvef B-Bloc No Rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8465	High Risk Recurrence Pro Ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G8473	Ace/Arb Thxpy Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8474	Ace/Arb Not Rx'D; Doc Reas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
G8475	Ace/Arb Thxpy Not Rx?D	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G8476	Bp Sys <140 And Dias <90	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
G8477	Bp Sys>=140 And/Or Dias >=90	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	<u>-</u>	-	-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8478	Bp Not Performed/Doc	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
G8482	Flu Immunize Order/Admin	service review.	-	-	-	-
G8483	Flu Imm No Admin Doc Rea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8484	Flu Immunize No Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
G9050	Oncology Work-Up Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
G9051	Oncology Tx Decision-Mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9052	Onc Surveillance For Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
G9053	Onc Expectant Management Pt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9054	Onc Supervision Palliative	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9055	Onc Visit Unspecified Nos	service review.	-	-	-	-
G9056	Onc Prac Mgmt Adheres Guide	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
G9057	Onc Pract Mgmt Differs Trial	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9058	Onc Prac Mgmt Disagree W/Gui	service review.	-	-	-	-
G9059	Onc Prac Mgmt Pt Opt Alterna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9060	Onc Prac Mgmt Dif Pt Comorb	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9061	Onc Prac Cond Noadd By Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G9062	Onc Prac Guide Differs Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
G9063	Onc Dx Nsclc Stgi No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9064	Onc Dx Nsclc Stg2 No Progres	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
G9065		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	Onc Dx Nsclc Stg3A No Progre	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9066	Onc Dx Nsclc Stg3B-4 Metasta	service review.	-	-	-	-
G9067	Onc Dx Nsclc Dx Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9068	Onc Dx Sclc/Nsclc Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	_
G9069	Onc Dx Scic/Nscic 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-	_	_	-	_
G9071	Onc Dx Brst Stg1-2B Hr Nopro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9072	Onc Dx Brst Stg1-2 Noprogres	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
G9073	Onc Dx Brst Stg3-Hr No Pro	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-	_	-	_	_
G9078	Onc Dx Prostate T2No Progres	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
G9079	Onc Dx Prostate T3B-T4Noprog	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9080	Onc Dx Prostate W/Rise Psa	service review.	-	-	-	-
G9083	Onc Dx Prostate Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9084	Onc Dx Colon T1-3 N1-2 No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9085	Onc Dx Colon T4 N0 W/O Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G9086	Onc Dx Colon T1-4 No Dx Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9087	Onc Dx Colon Metas Evid Dx	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9088	Onc Dx Colon Metas Noevid Dx	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_ -		
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9089	Onc Dx Colon Extent Unknown	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9090	Onc Dx Rectal T1-2 No Progr	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9091	Onc Dx Rectal T3 N0 No Prog	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-	_	_	_	_
G9095	Onc Dx Rectal Extent Unknwn	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9096	Onc Dx Esophag T1-T3 Noprog	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9097		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	_
	Onc Dx Esophageal T4 No Prog	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9098	Onc Dx Esophageal Mets Recur	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-				
G9104	Onc Dx Gastric Unknown Nos	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		<u>-</u>		_
G9105	Onc Dx Pancreatc P RO Res No	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9106	Onc Dx Pancreatc P R1/R2 No	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9107	Onc Dx Pancreatic Unresectab	service review.	-	-	-	-
G9108	Onc Dx Pancreatic Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9109	Onc Dx Head/Neck T1-T2No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9110	Onc Dx Head/Neck T3-4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G9111	Onc Dx Head/Neck M1 Mets Rec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
G9112	Onc Dx Head/Neck Ext Unknown	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9113	Onc Dx Ovarian Stg1A-B No Pr	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		-		
	<u> </u>	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9114	Onc Dx Ovarian Stg1A-B Or 2	service review.	-	-	-	-
G9115	Onc Dx Ovarian Stg3/4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9116	Onc Dx Ovarian Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9117	Onc Dx Ovarian Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
G9123	Onc Dx Cml Chronic Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
G9124	Onc Dx Cml Acceler Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9125	Onc Dx Cml Blast Phase	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_	_	
G9126	Onc Dx Cml Remission	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9128	Onc Dx Multi Myeloma Stage I	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9129	Onc Dx Mult Myeloma Stg2 Hig	service review.	-	-	-	-
G9130	Onc Dx Multi Myeloma Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9131	Onc Dx Brst Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9132	Onc Dx Prostate Mets No Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9133	Onc Dx Prostate Clinical Met	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G9134	Onc Nhistg 1-2 No Relap No	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9135		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
	Onc Dx Nhl Stg 3-4 Not Relap	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9136	Onc Dx Nhl Trans To Lg Bcell	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9137	Onc Dx Nhl Relapse/Refractor	service review.	-	-	-	-
G9138	Onc Dx Nhl Stg Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9139	Onc Dx Cml Dx Status Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
G9140	Frontier Extended Stay Demo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_

G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous, By Any Means, Guided By The Results Of Measurements For:Respiratory Quotient; And/Or, Urine Urea Nitrogen (Uun); And/Or,	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
	Arterial, Venous Or Capillary Glucose;					
G9978	And/Or Potassium Concentration Remote E/M New Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9979	Remote E/M New Pt 20Mins	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		-	-	-
G9980	Remote E/M New Pt 30 Mins	service review.	-	-	-	-
G9981	Remote E/M New Pt 45Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9982	Remote E/M New Pt 60Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	-
G9983	Remote E/M Est. Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G9984	Remote E/M Est. Pt 15Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
G9985	Remote E/M Est. Pt 25Mins	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9986	Remote E/M Est. Pt 40Mins	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		<u>-</u>		
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9987	Bpci Advanced In Home Visit	service review.	-	-	-	-
H0046	Mental Health Service Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
H0047	Alcohol/Drug Abuse Svc Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J0121	Inj. Omadacycline 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J0122	Inj. Eravacycline 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.113	Abatacept		
J0129	Abatacept Injection	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J0172	Inj Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.137	Aducanumab-avwa	1/1/2022	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage		
J0180	Agalsidase Beta Injection	require Prior Authorization per contract agreement.	RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J0202	Injection Alemtuzumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.077	Alemtuzumab		
	injection ruemeacunido	require Prior Authorization per contract agreement.	10001.077		-	-
J0219	Inj Aval Alfa-Nqpt 4Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	2022-04-01	-
J0220	Alglucosidase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage		
		contract/clinical review.		Disorders Enzyme-Replacement Therapy for Lysosomal Storage		
J0221	Injection Alglucosidase Alfa (Lumizyme) 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Disorders	_	_
		<u> </u>		Specialty Medication Administration Site of Care		
J0222	Inj. Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.102	Specialty Medication Administration Site of Care Patisiran (Onpattro)	-	-
J0223	Inj Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.125	Givosiran	_	_
J0224	Inj. Lumasiran 0.5 Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096 RX501.133	Specialty Medication Administration Site of Care Lumasiran	2021-07-01	
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
J0256	Alpha 1 Proteinase Inhibitor	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
J0291	Inj. Plazomicin 5 Mg	predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J0490	Injection, Belimumab, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.116 RX501.096	Belimumab Specialty Medication Administration Site of Care	_	_
J0491		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.138		2022-04-01	
	Inj Anifrolumab-Fnia 1Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.138	Anifrolumab-fnia Benralizumab	2022-04-01	-
J0517	Inj. Benralizumab 1 Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J0565	Inj Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.093	Bezlotoxumab	_	_
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
J0567	Inj. Cerliponase Alfa 1 Mg	require Prior Authorization per contract agreement.	RX501.092	Cerliponase alfa	-	-
J0584	Injection Burosumab-Twza 1M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.058	Burosumab-twza	_	_
IOE 6 S		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.019	Specialty Medication Administration Site of Care Botulinum Toxin		
J0586	Abobotulinumtoxina	require Prior Authorization per contract agreement.	MED201.014	Treatment of Hyperhidrosis	-	-
J0587	Inj Rimabotulinumtoxinb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	-	-
J0588	Injection, Incobotulinumtoxin A, 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	-	-
J0593	Inj. Lanadelumab-Flyo 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.013	Management of Hereditary Angioedema (HAE) with C1		
J0598	C-1 Esterase Cinryze	require Prior Authorization per contract agreement.	RX501.096	Esterase Inhibitor, Human and Ecallantide Specialty Medication Administration Site of Care	-	-
J0638	Canakinumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.119 RX501.096	Canakinumab Specialty Medication Administration Site of Care	-	-
J0717	Certolizumab Pegol Inj 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.111 RX501.096	Certolizumab Pegol Specialty Medication Administration Site of Care	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
J0775	Collagenase Clost Hist Inj	require Prior Authorization per contract agreement.	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	-	-
J0791	Inj Crizanlizumab-Tmca 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.126 RX501.096	Crizanlizumab-tmca Specialty Medication Administration Site of Care	3/1/2021	_
J0800	Corticotropin Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	_
J0881	Darbepoetin Alfa Non-Esrd	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	_
J0885	Epoetin Alfa Non-Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	12/31/2021
		require Prior Authorization per contract agreement.				
J0888	Epoetin Beta Non Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	-
J0896	Inj luspatercept-aamt 0.25mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	_
		require Prior Authorization per contract agreement.		*		

		AAD Calestic December (control of control of control of the Aardied Delta, Calestic Colonia (control of control of contro				
J1096	Dexametha Opth Insert 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	U1H9U3.U24	Intravitreal, Punctum, and Intracameral Implants	-	6/30/2022
J1097	Phenylep Ketorolac Opth Soln	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J1290	Ecallantide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.013 RX501.096	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecaliantide Specialty Medication Administration Site of Care	-	-
J1300	Eculizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.066 RX501.096	Eculizumab Specialty Medication Administration Site of Care	-	-
J1301	Injection Edarayone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.095	Edaravone		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096	Specialty Medication Administration Site of Care	40/4/2022	_
J1302	Inj sutimlimab-jome 10 mg	predetermination to avoid post-service review.	RX501.087	Paudiaumah ausa	10/1/2022	
J1303	Inj. Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.107 RX501.096	Ravulizumab-cwvz Specialty Medication Administration Site of Care	-	-
J1305	Inj evinacumab-dgnb 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.136	Evinacumab-dgnb	10/1/2021	_
J1306	Injection inclisiran 1 mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.142	Inclisiran	7/1/2022	
71500	injection inclision 1 mg	predetermination to avoid post-service review.		Enzyme-Replacement Therapy for Lysosomal Storage	7/1/2022	_
J1322	Elosulfase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067 RX501.096	Disorders Specialty Medication Administration Site of Care Advanced Therapies for Pharmacologic Treatment of	-	-
J1325	Epoprostenol Injection	require Prior Authorization per contract agreement.	RX501.056	Pulmonary Hypertension	-	-
J1426	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.135	Casimersen	10/1/2021	_
J1427	Vitolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.129	Viltolarsen	5/1/2021	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				_
J1428	Inj Eteplirsen 10 Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.084	Eteplirsen	-	-
J1429	Inj Golodirsen 10 Mg	predetermination to avoid post-service review.	RX501.122	Golodirsen	-	-
J1458	Galsulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous		
J1459	Inj Ivig Privigen 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	[IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1551	Ini cutaquia 100 ma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	BA204 003	Immunoglobulin (Ig) Therapy (Including Intravenous	7/1/2022	
	Inj cutaquig 100 mg	require Prior Authorization per contract agreement.	RX504.003	[IVIG] and Subcutaneous Ig [SCIG])	7/1/2022	-
J1554	Injection, Immune Globulin (Asceniv), 500Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	4/1/2021	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous		
J1555	Inj Cuvitru 100 Mg	require Prior Authorization per contract agreement.	RX501.096	[IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1556	Inj Imm Glob Bivigam 500Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1557	Injection, Immune Globulin, (Gammaplex), Intravenous, Non- Lyophilized (E.G. Liquid), 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1558	Inj. Xembify 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1559	Hizentra Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1561	Gamunex-C/Gammaked	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1562	Vivaglobin Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous		11/30/2022
J1566		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	[IVIG] and Subcutaneous Ig [SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous		
11300	Immune Globulin Powder	require Prior Authorization per contract agreement.	RX501.096	[IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	_	11/30/2022
J1568	Octagam Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	_	11/30/2022
J1569	Gammagard Liquid Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1572	Flebogamma Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1575	Hyqvia 100Mg Immuneglobulin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care	-	11/30/2022
J1599	Ivig Non-Lyophilized Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	11/30/2022
J1602	Golimumab For Iv Use 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.112 RX501.096	Golimumab Specialty Medication Administration Site of Care	-	-
J1632	Inj. Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.106	Brexanolone for Postpartum Depression	_	_
J1729	Inj Hydroxyprogst Capoat Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MD Criteria: Procedure (consists reviewed against Modical Policy Criteria, may	DVE01.067	Enzyme-Replacement Therapy for Lysosomal Storage		
J1743	Idursulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J1745	Infliximab Not Biosimil 10Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.028 RX501.051	Acne Management Infliximab and Associated Biosimilars	-	-
J1746	Inj. Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.099 RX501.096	Specialty Medication Administration Site of Care Ibalizumab-uiyk Specialty Medication Administration Site of Care	_	-
		require Prior Authorization per contract agreement.		Specialty Medication Administration Site of Care Enzyme-Replacement Therapy for Lysosomal Storage		
J1786	Imuglucerase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J1823	Inj. Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.127	Inebilizumab-cdon	3/1/2021	-

				Enzyme-Replacement Therapy for Lysosomal Storage		
J1931	Laronidase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J1943	Inj. Aristada Initio 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	_
J1944	Aripirazole Lauroxil 1 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	
J1951	Inj Fensolvi 0.25 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and		
	inj relison o.25 mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.080	Antagonists Mepolizumab	1011 07 01	_
J2182	Injection Mepolizumab 1Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2278	Ziconotide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.060	Ziconotide	-	-
J2323	Natalizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.059 RX501.096	Natalizumab Specialty Medication Administration Site of Care	-	10/1/2022
J2326	Inj Nusinersen 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.086	Nusinersen	-	10/15/2022
J2350	Injection Ocrelizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.085 RX501.096	Ocrelizumab Specialty Medication Administration Site of Care	_	-
J2356	Inj tezepelumab-ekko 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.143	Tezepelumab-ekko	7/1/2022	_
J2357	Omalizumab Injection	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.058 RX501.096	Omalizumab Specialty Medication Administration Site of Care	-	_
J2440	Papaverin Hcl Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030	Sexual Dysfunctions, Assessment and Treatment		
J2502		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			_	_
	Inj Pasireotide Long Acting	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.079	Photodynamic Therapy (PDT) for Choroidal	-	-
J2503	Pegaptanib Sodium Injection	predetermination to avoid post-service review.	OTH903.015	Neovascularization (CNV)	_	-
J2507	Injection Pegloticase 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.120 RX501.096	Pegloticase Specialty Medication Administration Site of Care	-	-
J2562	Plerixafor Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J2777	Inj faricimab-svoa 0.1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.044	Faricimab-svoa	10/1/2022	
J2778	Ranibizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	-	
J2779	Inj susvimo 0.1 mg	predetermination to avoid post-service review.	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	7/1/2022	-
J2786	Injection Reslizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.083 RX501.096	Reslizumab Specialty Medication Administration Site of Care	-	-
J2787	Riboflavin 5'Phos Opth<=3Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.028	Corneal Collagen Cross-Linking	_	6/30/2022
J2798	Inj. Perseris 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
12940	In Colonition of the A AA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage		
J2840	Inj Sebelipase Alfa 1 Mg	require Prior Authorization per contract agreement.	RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J2860	Injection Siltuximab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	-
J3031	Inj. Fremanezumab-Vfrm 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J3032	Inj. Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.124 RX501.096	Eptinezumab-jjmr Specialty Medication Administration Site of Care	_	_
			RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage		
J3060	Inj Taliglucerace Alfa 10 U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J3111	Inj. Romosozumab-Aqqg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J3121	Inj Testostero Enanthate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Testosterone Replacement Therapies	-	-
J3145	Testosterone Undecanoate 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
J3241	Inj. Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Testosterone Replacement Therapies Specialty Medication Administration Site of Care		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.110 RX501.096	Teprotumumab Specialty Medication Administration Site of Care		-
J3245	Inj. Tildrakizumab 1 Mg	require Prior Authorization per contract agreement.	RX501.123	Tildrakizumab-asmn	-	-
J3262	Tocilizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.115	Specialty Medication Administration Site of Care Tocilizumab	-	-
J3285	Treprostinil Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	-
J3301	Triamcinolone Acet Inj Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	5/4/2021
J3315	Triptorelin Pamoate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J3316	Inj. Triptorelin Xr 3.75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.041 RX501.040	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	-	-
J3358	Ustekinumab Iv Inject 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.114	Human Growth Hormone (GH) Specialty Medication Administration Site of Care Ustekinumab	-	-
J3380	Injection Vedolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.117	Specialty Medication Administration Site of Care Vedolizumab	-	-
12267	Voluntaria	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage		
J3385	Velaglucerase Alfa	require Prior Authorization per contract agreement.	RX501.096	Disorders Specialty Medication Administration Site of Care	-	-
J3396	Verteporfin Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	_	6/30/2022
J3397	Inj. Vestronidase Alfa-Vjbk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_
J3398	Inj Luxturna 1 Billion Vec G	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care Gene Therapy for Inherited Retinal Dystrophy		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			-	-
J3399	Inj Onase Abepar-Xioi Treat	require Prior Authorization per contract agreement.	RX501.104	Onasemnogene Abeparvovec-xioi	-	-

13490	Drugs Unclassified Injection	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED206.001 RX501.135 RX501.063 SUR716.001 RX501.067 RX501.067 RX501.067 RX501.087 RX501.080 SUR706.001 RX501.080 SUR706.001 RX501.086 RX501.086 RX501.086 RX501.086 RX501.087 RX501.087 RX501.088	Amergy Warnagement Cossimersen Compounded Drug Products Cosselter and Reconstructive Procedures Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders Esketamine Nasal Spray FDA-Approved Drugs and Biologicals Human Growth Hormone (GH) Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Mepolizumab Nasal and Sinus Surgery Nusinersen Ocrelizumab Orasemnogene Abeparvovec-xiol Rethymic Rethymic Rethymic Rethymic Treatment of Hyperhidrosis Veklury Viltolarsen	-	-
J3520	Edetate Disodium Per 150 Mg	predetermination to avoid post-service review.	THE801.008	Chelation Therapy	-	_
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.135 RX501.073 RX501.063 RX501.141 RX501.067 RX501.087 RX504.003 RX501.051 RX501.080 RX501.080 RX501.104 RX501.104 RX501.139 RX501.129	Casimersen Clostridial Collagenase for Fibroproliferative Disorders Compounded Drug Products Efgartigimod alfa-fcab Enzyme-Replacement Therapy for Lysosomal Storage Disorders FDA-Approved Drugs and Biologicals Immunoglobulin (tg) Therapy (Including Intravenous [IVIG] and Subcutaneous [g [SCIG]) Infilizimab and Associated Biosimilars Mepolizumab Ocrelizumab Ocnselmongene Abeparvovec-xioi Rethymic Viltolarsen	-	-
J3591	Esrd On Dialysi Drug/Bio Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
J7177	Inj. Fibryga 1 Mg	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J7178		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.072			-
	Inj Human Fibrinogen Con Nos	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J7192	Factor Viii Recombinant Nos	contract/clinical review.	-	-	-	-
J7195	Factor Ix Recombinant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	
J7199	University Class France No.	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
1/199	Hemophilia Clot Factor Noc	contract/clinical review.	-	-	-	-
J7309	Methyl Aminolevulinate Top	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.027	Dermatologic Applications of Photodynamic Therapy (PDT)	-	_
J7314	Inj. Yutiq 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.024	Intravitreal, Punctum, and Intracameral Implants	-	6/30/2022
J7316	Inj Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.026	Ocriplasmin for Symptomatic Vitreomacular Adhesion	_	-
J7340	Carbidopa Levodopa Ent 100Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.015	Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease.	-	-
J7351	Inj Bimatoprost Itc Imp1Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.024	Intravitreal, Punctum, and Intracameral Implants	_	6/30/2022
17404		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
J7401	Mometasone Furoate Sinus Imp	predetermination to avoid post-service review.	#N/A	#N/A	-	3/31/2021
J7402	Mometasone Sinus Sinuva	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.001	Nasal and Sinus Surgery	5/15/2021	_
J7599	Immunosuppressive Drug Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
J7604	Acetylcysteine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7607	Levalbuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7609	Albuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7610	Albuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7615	Levalbuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7622	Beclomethasone Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7624	Betamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7627	Budesonide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7628	Bitolterol Mesylate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7629	Bitolterol Mesylate Comp Unt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7632	Cromolyn Sodium Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7634	Budesonide Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7635	Atropine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7636	Atropine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
J7637	Dexamethasone Comp Con	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7638	Dexamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7640	Formoterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7641	Flunisolide Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7642	Glycopyrrolate Comp Con	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
J7643	Glycopyrrolate Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7645	Ipratropium Bromide Comp	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7647	Isoetharine Comp Con	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7650	Isoetharine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7657	Isoproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	-
J7660	Isoproterenol Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7667	Metaproterenol Comp Con	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	PV501 062	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
J7670	Metaproterenol Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7676	Pentamidine Comp Unit Dose	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7680	Terbutaline Sulf Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7681	Terbutaline Sulf Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7683	Triamcinolone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	-	-
J7684	Triamcinolone Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7685	Tobramycin Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	PV501 062	Compounded Drug Products		
J7699	Inhalation Solution For Dme	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	10.501.003	composited 51 ag 11 odded	-	-
J7799	Non-Inhalation Drug For Dme	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	-
J7999	Compounded Drug Noc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	-
	· · · ·	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
J8498	Antiemetic Rectal/Supp Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
J8499	Oral Prescrip Drug Non Chemo	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
J8597	Antiemetic Drug Oral Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
J8999	Oral Prescription Drug Chemo	contract/clinical review.	-	-	-	-
J9020	Asparaginase Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J9022	Inj Atezolizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9023	Injection Avelumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9032	Injection Belinostat 10Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9035	Bevacizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	OTH903.020 OTH903.015	Bevacizumab for Ophthalmological Indications Photodynamic Therapy (PDT) for Choroidal	_	12/31/2021
J9037	Injection, Belantamab Mafodontin-	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Neovascularization (CNV) Oncology Medications	Moved to PA list	
	Blmg, 0.5Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may		Oncology intedications	Woved to FA list	-
J9039	Injection Blinatumomab	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	-
J9043	Injection Cabazitaxel 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9044	Inj Bortezomib Nos 0.1 Mg	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J9047	Injection Carfilzomib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9057	Inj. Copanlisib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	Moved to PA list	-
J9118	Inj. Calaspargase Pegol-Mknl	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A	Retired 2019	_
J9119	Inj. Cemiplimab-Rwlc 1 Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	-
J9144	Daratumumab Hyaluronidase	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9145	Injection Daratumumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9153	Inj Daunorubicin Cytarabine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9155	Degarelix Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9173	Inj. Durvalumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9176	Injection Elotuzumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9177	Inj Enfort Vedo-Ejfv 0.25Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021

J9203	Gemtuzumab Ozogamicin 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	_
J9204	Inj Mogamulizumab-Kpkc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
J9205	Inj Irinotecan Liposome 1 Mg	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9210	Inj. Emapalumab-Lzsg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	-
J9219	Leuprolide Acetate Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	Moved to PA list	12/31/2021
J9223	Inj. Lurbinectedin 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9225	Vantas Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9226	Supprelin La Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	Moved to PA list	12/31/2021
J9227	Inj. Isatuximab-Irfc 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9228	Injection Ipilimumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9229	Inj Inotuzumab Ozogam 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	_
J9264	Paclitaxel Protein Bound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9269	Inj. Tagraxofusp-Erzs 10 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9271	Inj Pembrolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	_	10/10/2021
J9281	Mitomycin Instillation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9285	Inj Olaratumab 10 Mg	require Prior Authorization per contract agreement. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		·	5/15/2021	
J9295	Injection Necitumumab 1 Mg	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	_	12/31/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061		-	
J9299	Injection Nivolumab	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9301	Obinutuzumab Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
19306	Injection Pertuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
19308	Injection Ramucirumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
19309	Inj Polatuzumab Vedotin 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	-
J9311	Inj Rituximab Hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9312	Inj. Rituximab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	-	12/31/2021
J9313	Inj. Lumoxiti 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	_
J9316	Injection, Pertuzumab, Trastuzumab, And Hyaluronidase-Zzxf, Per 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9317	Sacituzumab Govitecan-Hziy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
J9325	Inj Talimogene Laherparepvec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9332	Inj efgartigimod 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.141	Efgartigimod alfa-fcab	7/1/2022	_
19349	Injection, Tafasitamab-Cxix, 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	_
19352	Injection Trabectedin 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	-
J9354	Inj Ado-Trastuzumab Emt 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
19358	Inj Fam-Trastu Deru-Nxki 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
19600	Porfimer Sodium Injection	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.029	Oncologic Applications of Photodynamic Therapy,		
	. ,	predetermination to avoid post-service review.	MED203.002	Including Barrett Esophagus Antineoplaston Cancer Therapy		
		Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.063 RX501.087	Compounded Drug Products FDA-Approved Drugs and Biologicals		
19999	Chemotherapy Drug	contract/clinical review. May require PA per contract agreement.	RX504.003 RX501.085	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
			RX501.085 RX501.057	Ocrelizumab Sodium Phenvlbutvrate		
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0010	Stnd Wt Frame Power Whichr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0011	Stnd Wt Pwr Whichr W Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0012	Ltwt Portbl Power Whichr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0013	Custom Power Whichr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure of the procedure of	DME101.010	Wheelchairs and Accessories	-	_
K0014	Other Power Whichr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Medical Policy Criteria Submit for MP Criteria Penedure (review policy and project Medical Policy Criteria Submit for	DME101.010	Wheelchairs and Accessories	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0053	Elevate Footrest Articulate	MD Criteria: Procedure/consider residenced against No dis-10-11-10-10	DME101.010	Wheelchairs and Accessories	-	_
K0065	Spoke Protectors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.				
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.		Wheelchairs and Accessories	-	-
K0065	Spoke Protectors	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	-
K0108	Spoke Protectors W/C Component-Accessory Nos	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.	DME101.010	Advanced Therapies for Pharmacologic Treatment of	- -	- -
K0108 K0455	Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/Clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010 RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	- - -
K0108 K0455 K0800	Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pov Group 1 Std Up To 300Lbs	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010 RX501.056 DME101.010	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension Wheelchairs and Accessories	- - -	- - -
K0108 K0455 K0800 K0801	Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pov Group 1 Std Up To 300Lbs Pov Group 1 Hd 301-450 Lbs	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/Clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria.	DME101.010 RX501.056 DME101.010 DME101.010	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension Wheelchairs and Accessories Wheelchairs and Accessories	-	-

K0808	Pov Group 2 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0812	Power Operated Vehicle Noc	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	DME101 010	Wheelchairs and Accessories		
NOOIL	rower operated venicle Not	contract/clinical review.		Wileekilaii 3 alid Accessories	-	_
K0813	Pwc Gp 1 Std Port Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0814	Pwc Gp 1 Std Port Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0815	Pwc Gp 1 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0816	Pwc Gp 1 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0820	Pwc Gp 2 Std Port Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0821	Pwc Gp 2 Std Port Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0822	Pwc Gp 2 Std Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010		-	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	
K0823	Pwc Gp 2 Std Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0824	Pwc Gp 2 Hd Seat/Back	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0825	Pwc Gp 2 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0826	Pwc Gp 2 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0827	Pwc Gp Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0828	Pwc Gp 2 Xtra Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0829	Pwc Gp 2 Xtra Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0830	Pwc Gp2 Std Seat Elevate S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0831		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010		-	
	Pwc Gp2 Std Seat Elevate Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	_	_
K0835	Pwc Gp2 Std Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0836	Pwc Gp2 Std Sing Pow Opt Cap	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0837	Pwc Gp 2 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0838	Pwc Gp 2 Hd Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0839	Pwc Gp2 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0840	Pwc Gp2 Xhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0841	Pwc Gp2 Std Mult Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0842	Pwc Gp2 Std Mult Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0843	Pwc Gp2 Hd Mult Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
K0848	Pwc Gp 3 Std Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0849	Pwc Gp 3 Std Cap Chair	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0850	Pwc Gp 3 Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0851	Pwc Gp 3 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0852	Pwc Gp 3 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0853	Pwc Gp 3 Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0854	Pwc Gp 3 Xhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0855	Pwc Gp 3 Xhd Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0856	Pwc Gp3 Std Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0857	Pwc Gp3 Std Sing Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0858	Pwc Gp3 Hd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0859	Pwc Gp3 Hd Sing Pow Opt Cap	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0860	Pwc Gp3 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0861	Pwc Gp3 Std Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0862	Pwc Gp3 Hd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0863	Pwc Gp3 Vhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0864	Pwc Gp3 Xhd Mult Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0868	Pwc Gp 4 Std Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0869		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
	Pwc Gp 4 Std Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0870	Pwc Gp 4 Hd Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0871	Pwc Gp 4 Vhd Seat/Back	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0877	Pwc Gp4 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0878	Pwc Gp4 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
K0879	Pwc Gp4 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0880	Pwc Gp4 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0884	Pwc Gp4 Std Mult Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0885	Pwc Gp4 Std Mult Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
K0886	Pwc Gp4 Hd Mult Pow S/B	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0890	Pwc Gp5 Ped Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0891	Pwc Gp5 Ped Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
		Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
K0898	Power Wheelchair Noc	contract/clinical review.		-		

K1002	Ces System W/Supplies Access	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	-	-
K1003	Whirlpool Tub Walkin Portabl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
K1004	Lo Freq Us Diathermy Device	Service Teview. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE803.008	Non-Covered Physical Therapy Services	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Powered Exoskeleton for Ambulation in Patients With		
K1007	Bil Hkaf Pc S/D Micro Sensor	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME103.008	Lower-Limb Disabilities	3/1/2021	-
K1009	Speech Volume Modulation Sys	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.014	Speech-Language Therapy (SLT)	3/1/2021	-
К1018	Ext Up Limb Tremor Stim Wris	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2021-08-15	-
К1019	Monthly Supp Use With K1018	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2021-08-15	-
K1020	Non-Invasive Vagus Nerv Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR712.021	Vagus Nerve Stimulation (VNS)	2021-07-01	_
K1023	Trans elec nerv periph nerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	1/1/2022	-
K1023	Trans elec nerv periph nerv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	10/1/2021	12/31/2021
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2022	_
K1024	Non pneum comp control cal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven	10/1/2021	12/31/2021
K1025	Non pneum compress full arm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Procedures/Services Experimental, Investigational and/or Unproven Procedures/Services	1/1/2022	-
K1025	Non pneum compress full arm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven	10/1/2021	12/31/2021
K1027	Oral dev without fix mech	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	MED204.005	Procedures/Services Diagnosis and Medical Management of Sleep Related	10/1/2021	
K1030		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.068	Breathing Disorders Cardiac Contractility Modulation (CCM) Device		-
	Ext Recharge Bat Replacement	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Experimental. Investigational and/or Unproven	2022-04-01	-
K1031	Non Pneu Comp Control W/O Ca	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Procedures/Services	2022-04-01	-
K1032	Non Pneum Seq Comp Full Leg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	-
K1033	Non Pneum Seq Comp Half Leg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	-
L0999	Add To Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Light Procedure/service not specifically defined or classified may be subject to	-	-	-	-
L1499	Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
L1834	Ko W/O Joint Rigid Molded To	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	-	6/30/2022
L1840	Ko Derot Ant Cruciate Custom	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	_	6/30/2022
L1844	Ko W/Adj Jt Rot Cntrl Molded	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	_	_
L1846	Ko W Adj Flex/Ext Rotat Mold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	-	6/30/2022
L2006	Kaf Sng/Dbl Swg/Stn Mcpr Cus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-		-	-
L2999	Lower Extremity Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
L3040	Ft Arch Suprt Premold Longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
L3050	Foot Arch Supp Premold Metat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
L3060	Foot Arch Supp Longitud/Meta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
L3649	Orthopedic Shoe Modifica Nos	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
L3999		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
	Upper Limb Orthosis Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	Lower-Limb Prosthetics, Including Microprocessor-	-	-
L5857	Elec Knee-Shin Swing Only	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIVIE104.012	Controlled Prosthetics Lower-Limb Prosthetics, Including Microprocessor-	_	-
L5973	Ank-Foot Sys Dors-Plant Flex	predetermination to avoid post-service review. MP Criteria: Procedure/service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.012	Controlled Prosthetics	-	-
L5981	Flex-Walk Sys Low Ext Prosth	wire Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	DIVIC104.012	Lower-Limb Prosthetics, Including Microprocessor- Controlled Prosthetics	_	6/30/2022
L5999	Lowr Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	- University by December 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-	-
L6026	Part Hand Myo Exclu Term Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6611	Additional Switch Ext Power	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	'- <u> </u>	-
L6621	Flex/Ext Wrist W/Wo Friction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	6/30/2022
L6880	Electric Hand Switch Or Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	'-	-
L6882	Includes Motor(S) Microprocessor Control Uplmb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	·_	6/30/2022
L6920	Wrist Disarticul Switch Ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	·_	-
L6925	Wrist Disart Myoelectronic C	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for		_
L6930	Below Elbow Switch Control	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for		-
-3330	SCION EIDOW SWITCH COULD	predetermination to avoid post-service review.	DWIE104.001	Lower-Limb Prosthesis	_	-
L6935	Below Elbow Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6940	Elbow Disarticulation Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6945	Elbow Disart Myoelectronic C	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-

L6950	Above Elbow Switch Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	_	-
L6955	Above Elbow Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for		
	7,550 C Elsow Myselectionic CC	predetermination to avoid post-service review.		Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and		
L6960	Shldr Disartic Switch Contro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6965	Shldr Disartic Myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6970	Interscapular-Thor Switch Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6975	Interscap-Thor Myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7007	Adult Electric Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	_	6/30/2022
L7008	Pediatric Electric Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	-	
L7009	Adult Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	_	_
L7040	Prehensile Actuator	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and		-
L7045	Pediatric Electric Hook	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and	-	-
L7170	Electronic Elbow Hosmer Swit	predetermination to avoid post-service review.		Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and	_	-
L7180	Electronic Elbow Sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7181	Electronic Elbo Simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis		
L7185	Electron Elbow Adolescent Sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7186	Electron Elbow Child Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	-	-
L7190	Elbow Adolescent Myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	-	-
L7191	Elbow Child Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	-	
L7259	Electronic Wrist Rotator Any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	_	6/30/2022
L7364	Twelve Volt Battery Utah/Equ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	_	_
L7366	Battery Chrgr 12 Volt Utah/E	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Lower-Limb Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for		
L7499		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		Lower-Limb Prosthesis		
L8039	Upper Extremity Prosthes Nos Breast Prosthesis Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
L8048		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	_
	Unspec Maxillofacial Prosth	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
L8499	Unlisted Misc Prosthetic Ser	contract/clinical review.	-	- Injectable Bulking Agents for the Treatment of Usingsy.	-	-
L8604	Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of	-	-
L8605	Inj Bulking Agent Anal Canal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR710.008	Vesicoureteral Reflux (VUR) Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	-	-
		Policy (CPCP).		Injectable Bulking Agents for the Treatment of Urinary		
L8606	Synthetic Implnt Urinary 1Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008 SUR710.022	and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	-	-
L8608	Arg Ii Ext Com/Sup/Acc Misc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Retinal Prosthesis	-	-
L8612	Aqueous Shunt Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	-	-
L8614	Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8615	Coch Implant Headset Replace	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8616	Coch Implant Microphone Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8617	Coch Implant Trans Coil Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8618	Coch Implant Tran Cable Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant		
L8619	Coch Imp Ext Proc/Contr Rplc	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			-	_
L8621	Repl Zinc Air Battery	require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8623	Lith Ion Batt Cid Non-EarlvI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-

L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8628	Cid Ext Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8629	Cid Transmit Coil And Cable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8690	Aud Osseo Dev Int/Ext Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
L8691	Aoi Snd Proc Repl Excl Actua	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
L8693	Aud Osseo Dev Abutment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	_
L8694	Aoi Transducer/Actuator Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR714.003	Implantable Bone-Conduction and Bone-Anchored		6/30/2022
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	301724.003	Hearing Aids	-	0/30/2022
L8699	Prosthetic Implant Nos	contract/clinical review.	-	-	-	-
L8701	Ewh S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L8702	Ewhf S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
M0076	Prolotherapy	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.013	Prolotherapy	1/1/2023	_
M0076	Prolotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.013	Prolotherapy	10/1/2022	12/31/2022
P2031	Hair Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Autism Spectrum Disorders (ASD)	10/1/2022	12/31/2022
	Tun Mulysis	predetermination to avoid post-service review.	131302.024	Orthopedic Applications of Platelet-Rich Plasma	-	_
P9020	Plaelet Rich Plasma Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
P9099	Blood Component/Product Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_		_	_
		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
Q0239	Bamlanivimab-Xxxx	service review.	-	-	-	4/16/2021
Q0507	Misc Sup/Acc Ext Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
Q0508	Misc Sup/Acc Imp Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
Q0509	Mis Sup/Ac Imp Vad Nopay Med	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
Q0510	Dispens Fee Immunosupressive	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-	_	_	_	_
Q2026	Radiesse Injection	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUP716 001	Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
Q2028	Inj Sculptra 0.5Mg	predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	_
Q2039	Influenza Virus Vaccine Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
Q2041	Axicabtagene Ciloleucel Car+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	-
Q2042	Tisagenlecleucel Car-Pos T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	-
Q2043	Sipuleucel-T Minimum Of 50 Million Autologous Cd54+ Cells Activated With Pap-Gm-Csf Including Leukapheresis And All Other Preparatory Procedures Per Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
Q2050	Doxorubicin Inj 10Mg	Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX502.061	Oncology Medications	_	_
Q2052		contract/clinical review. May require PA per contract agreement. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
Q2032	Ivig Demo Services/Supplies Brexucabtagene Autoleucel, Up To 200	service review.	-	-	-	-
Q2053	Million Autologous Anti-Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	4/1/2021	-
Q2054	Lisocabtagene mara car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	10/1/2021	-
Q2055	Idecabtagene Vicleucel Car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	1/1/2022	-
Q2056	Ciltacabtagene car-pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	10/1/2022	
Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
Q4051	Splint Supplies Misc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
Q4082	Drug/Bio Noc Part B Drug Cap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
Q4100	Skin Substitute Nos	Unitsted: Procedure/service not specifically defined or classified MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4101	Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
Q4102	Oasis Wound Matrix	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4103	Oasis Burn Matrix	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4104	Integra Bmwd	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4105	Integra Drt Or Omnigraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	
Q4106	Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4107	Graftjacket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_
L	w	predetermination to avoid post-service review.		3	-	-

Q4108	Integra Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4110	Primatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4111	Gammagraft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4112	Cymetra Injectable	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
Q4113		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
	Graftjacket Xpress	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4114	Integra Flowable Wound Matri	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	-
Q4115	Alloskin	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4118	Matristem Micromatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4121	Theraskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4122	Dermacell Awm Porous Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	10/14/2021
Q4122	Dermacell Awm Porous Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes	10/15/2021	_
Q4122	Dermacell Awm Porous Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	3/31/2021
Q4123	Alloskin Rt Per Square Centimeter	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4125	Arthroflex Per Square Centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4126	Memoderm/Derma/Tranz/Integup	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
Q4127 Q4128	Talymed Per Square Centimeter Flexhd/Allopatchhd/Matrixhd	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
	<u> </u>	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			_	-
Q4130	Strattice Tm Per Square Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4132	Grafix core grafixpl core	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Amniotic Membrane and Amniotic Fluid	08/15/2021	_
Q4133	Grafix stravix prime pl sqcm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4134	Hmatrix	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4135	Mediskin	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4136	Ezderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4137	Amnioexcel Biodexcel 1Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4138	Biodfence Dryflex 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4139	Amnio Or Biodmatrix Inj 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4140	Biodfence 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4141	Alloskin Ac 1 Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4142	Xcm Biologic Tiss Matrix 1Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
Q4143	Repriza 1Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4145	Epifix Inj 1Mg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4146	Tensix 1Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4147	Architect Ecm Px Fx 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4148	Neox Neox Rt Or Clarix Cord	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4150	Allowrap Ds Or Dry 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	-	-
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4152	Dermapure 1 Square Cm	Freder miniation to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4153	Dermavest Plurivest Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4154	Biovance 1 square cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-

Q4155	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4156	Neox 100 Or Clarix 100	FUIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01	11 Amniotic Membrane and Amniotic Fluid		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
Q4157	Revitalon 1 Square Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4158	Kerecis Omega3 Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01. Policy (CPCP).	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4159	Affinity1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	1/31/2022
Q4159	Affinity1 Square Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	11 Amniotic Membrane and Amniotic Fluid	2/1/2022	-
Q4160	Nushield 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4161	Bio-Connekt Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4162	Wndex Flw Bioskn Flw 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4163	Woundex Bioskin Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4164	Helicoll Per Square Cm	FOIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01:	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
Q4165	Keramatrix Kerasorb Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01:	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-
Q4166	Cytal Per Square Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01: Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4167	Truskin Per Sq Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01:		5/15/2021	-
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. SUR704.01	11 Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4169	Artacent Wound Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4170	Cygnus Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4171	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4173	Palingen Or Palingen Xplus	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4174	Palingen Or Promatrx	Foliary (E-CF): EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP):	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4175	Miroderm	Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	12 Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	-
Q4176	Neopatch Or Therion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPC)	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4178	Floweramniopatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP)	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4179	Flowerderm Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01: Policy (CPCP).	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4180	Revita Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPC).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4181	Amnio Wound Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP)	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4182	Transcyte Per Sq Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01:	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4183	Surgigraft 1 Sq Cm	Policy (PCPP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCP08, which is one of our Clinical Payment and Coding SUR704.01	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4184	Cellesta Or Duo Per Sq Cm	Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service			
		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-	-
Q4185	Cellesta Flowab Amnion 0.5Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP). MR Collector Proceedures (consign reviewed against Medical Bolicy Criteria, Submit for		-	-
Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. SUR704.01		08/15/2021	_
Q4187	Epicord 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	11 Amniotic Membrane and Amniotic Fluid	08/15/2021	
Q4188	Amnioarmor 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4189	Artacent Ac 1 Mg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4190	Artacent Ac 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4191	Restorigin 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4192	Restorigin 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01 Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4193	Coll-E-Derm 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.01.	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4194	Novachor 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	11 Amniotic Membrane and Amniotic Fluid	-	-
Q4195	Puraply 1 Sq Cm	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	12 Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
		· Ones (co. Cr.).			

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4196	Puraply Am 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4197	Puraply Xt 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4198	Genesis Amnio Membrane 1Sqcm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4199	Cygnus Matrix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	2022-04-15	-
Q4200	Skin Te 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4201	Matrion 1 Sq Cm	Policy (EPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4202	Keroxx (2.5G/Cc) 1Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4203	Derma-Gide 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPOB, which is one of our Clinical Payment and Coding SUR70	04.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4204	Xwrap 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid		_
Q4205	Membrane Graft Or Wrap Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70		Amniotic Membrane and Amniotic Fluid		
Q4206	Fluid Flow Or Fluid Gf 1 Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Amniotic Membrane and Amniotic Fluid	-	-
		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
Q4208	Novafix Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4209	Surgraft Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4210	Axolotl Graf Dualgraf Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4211	Amnion Bio Or Axobio Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4212	Allogen Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4213	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4214	Cellesta Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4215	Axolotl Ambient Cryo 0.1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPC).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4216	Artacent Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4217	Woundfix Biowound Plus Xplus	FILLY Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4218	Surgicord Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid		
Q4219	Surgigraft Dual Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70		Amniotic Membrane and Amniotic Fluid	<u>-</u>	
Q4220	Bellacell Hd Surederm Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, which is one of our Clinical Payment and Coding SUR70		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4220	Bellacell Hd Surederm Sq Cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR70.		Bioengineered Skin and Soft Tissue Substitutes	3/13/2021	5/14/2021
Q4221		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70				3/14/2021
Q#221	Amniowrap2 Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4222	Progenamatrix Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR70		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
Q4222	Progenamatrix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Bioengineered Skin and Soft Tissue Substitutes	_	5/14/2021
Q4224	Hhf10-P Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	04.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4225	Amniobind Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4227	Amniocore Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4228	Bionextpatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	9/30/2021
Q4229	Cogenex Amnio Memb Per Sq Cm	EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP).	04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4230	Cogenex Flow Amnion 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4231	Corplex P Per Cc	Policy (EPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4232	Corplex Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4233	Surfactor /Nudyn Per 0.5 Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPOB, which is one of our Clinical Payment and Coding SUR70	04.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4234	Xcellerate Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70		Amniotic Membrane and Amniotic Fluid		
Q4235	Amniorepair Or Altiply Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70		Amniotic Membrane and Amniotic Fluid		
	погерол от лируу эц СП	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid	-	9/20/2021
04226	Caronatch Per Co Con		era(III	OUTPOSE METHOLOGIE AND AMBIOTIC Fluid	-	9/30/2021
Q4236 Q4237	Carepatch Per Sq Cm Cryo-Cord Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR70		Amniotic Membrane and Amniotic Fluid		

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4238	Derm-maxx, per sq cm	review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	7/1/2022	-
Q4238	Derm-maxx, per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	02.01/2022	6/30/2022
Q4239		EU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4240	Corecyte Topical Only 0.5 Cc	Foliary (CCCF). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4241	Polycyte Topical Only 0.5Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR/04.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4242	Amniocyte Plus Per 0.5 Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4244	Procenta Per 200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4246	Coretext Or Protext Per Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4247	Amniotext Patch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4248	Dermacyte Amn Mem Allo Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4249	Amniply Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	_
Q4250	Amnioamp-Mp Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
Q4251	Vim per square centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4252	Vendaje per square centimet	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). No Clinical Payment and Coding Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4252	Vendaje per square centimet	Pointy (PCCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4253	Zenith amniotic membrane psc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4253	Zenith amniotic membrane psc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4254	Novafix DI Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4255	Reguard Topical Use Per Sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4256	Mlg Complet Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4257	Relese Per Sq Cm	Policy (CPCP). Ellu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4258	Enverse Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
04350	Celera dual layer or celera dual membra	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	CUD704 044	Amniotic Membrane and Amniotic Fluid	4/4/2022	
Q4259		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	42/24/2022
Q4259		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	12/1/2022	12/31/2022
Q4260	Signature apatch, per square centimete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	-
Q4260		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EII policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011		12/1/2022	12/31/2022
Q4261	Tag, per square centimeter	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	
Q4261 Q5009	Tag, per square centimeter Hospice Care Nos	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	12/1/2022	12/31/2022
Q5103	Injection Inflectra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.051 RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
Q5104	Injection Renflexis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.051 RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
Q5106	Inj Retacrit Non-Esrd Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	-
Q5107	Inj Mvasi 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
Q5109	Injection Ixifi 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.051	Infliximab and Associated Biosimilars	-	-
Q5115	Inj Truxima 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	-	-
Q5118	Inj. Zirabev 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
Q5119	Inj Ruxience 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	10/10/2021
Q5124	Inj. Byooviz 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.041	Ranibizumab Injections, Implants and Biosimilars	2022-04-01	_
S0013	Esketamine Nasal Spray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	2/1/2021	
S0117	Tretinoin Topical 5 G	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S0142	Colistimethate Inh Sol Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S0157	Becaplermin Gel 1% 0.5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
S0189	Testosterone Pellet 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 RX501.007 RX501.076	Conditions Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty	-	10/1/2022
				Testosterone Replacement Therapies		

		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S0197	Prenatal Vitamins 30 Day	service review.	-	-	-	-
S0310	Hospitalist Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S0320	Rn Telephone Calls To Dmp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
S0590	Misc Integral Lens Serv	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	-
S0622	Phys Exam For College	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
50800	Laser In Situ Keratomileusis	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.001	Refractive and Therapeutic Keratoplasty	_	
		predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	351713.001	nemative and merapeatic keratopiassy	-	-
50810	Photorefractive Keratectomy	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
\$1001	Deluxe Item	contract/clinical review.	-	-	_	-
S1002	Custom Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-		-	-
S1040	Cranial Remolding Orthosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.007	Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses	-	6/30/2022
S1091	Stent Non-Coronary Propel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.001	Nasal and Sinus Surgery	5/15/2021	-
S2083	Adjustment Gastric Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
S2112	Knee Arthroscp Harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal	2022-05-01	-
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Articular Cartilage Lesions		
S2117	Arthroereisis Subtalar	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	-	-
S2118	Total Hip Resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement until 03/31/2022.	SUR705.019	Hip Resurfacing (HR)	-	-
S2120	Low Density Lipoprotein(Ldl)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE802.003	Lipid Apheresis	_	_
52140	Cord Blood Harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.040 SUR703.040 SUR703.042 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acute Myyelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myyelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervou System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, including Multiple Myeloma (MM) and POEMS Syndrome (MM) and POEMS Syndrome (ME) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, including Multiple Myeloma (MM) and POEMS Syndrome (ME) Hematopoietic Cell Transplantation for Plasma Cell Hematopoietic Cell Transp	-	-
S2142	Cord Blood-Derived Stem-Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.038 SUR703.039 SUR703.039 SUR703.034 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.036 SUR703.044 SUR703.046 SUR703.046 SUR703.046 SUR703.045	Hematoopietic Cell Transplantation for Primary Hematoopietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervou System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervou System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphocytic Leukemia (Tumor) Hematopoietic Cell Transplantation for Central Myeloid Leukemia Hematopoietic Cell Transplantation for Fipthelial Ovarian Cancer Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastis Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Polisma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Hematopoietic Cell Transplantation for Primary	-	-

\$2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.043 SUR703.047 SUR703.037 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.043 SUR703.040 SUR703.042 SUR703.040 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphobiastic Leukemia (Akti) Hematopoietic Cell Transplantation for Acutie Immunodeficiency Syndrome (AlDS) Hematopoietic Cell Transplantation for Acutie Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acutie Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLI) and Small Lymphocytic Lymphoma (SLI) Hematopoietic Cell Transplantation for Chronic Myelodic Deukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Phodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Phasma Cell Dyscrasias, Induling Multiple Myeloma (MM) and POEMS Syndrome	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Hematopoietic Cell Transplantation for Primary		
S2202	Echosclerotherapy	MP Criteria: Procedure (corpice reviewed against Medical Policy Criteria, Submit for		Varicose Vein Management Semi-Implantable and Fully Implantable Middle Ear	_	
S2230	Implant Semi-Imp Hear	predetermination to avoid post-service review.	3UR/14.006	Hearing Aids	-	
S2235	Implant Auditory Brain Imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR714.009	Auditory Brainstem Implant	_	_
S2300	Arthroscopy Shoulder Surgi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.041	Thermal Capsulorrhaphy as a Treatment of Joint Instability	-	-
S2409	Fetal Surg Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
S2411	Fetoscop laser ther TTTS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	12/1/2022	
\$2900	Surgical Techniques Requiring Use Of Robotic Surgical System (List Separately In Addition To Code For Primary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery		-
S3600	Procedure) Stat Lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S3601	Stat Lab Home/Nf	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S3650	Saliva Test Hormone Level;	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.128	Salivary Hormone Testing	_	_
53652	Saliva Test Hormone Level;	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	-	-
S3900	Surface Emg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	_	-
S4015	Complete Ivf Nos Case Rate	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
S4023	Incompl Donor Egg Case Rate	Contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	
S4025	Donor Serv lvf Case Rate	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		<u> </u>	_	_
S4026	Procure Donor Sperm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	
S4027	Store Prev Froz Embryos	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	
S4030	Sperm Procure Init Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
S4031	Sperm Procure Subs Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
S4040	Monit Store Cryo Embryo 30 D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
S4990	Nicotine Patch Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S4991	Nicotine Patch Nonlegend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S4995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S5035	Hit Routine Device Maint	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	
S5036	Hit Device Repair	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	-	_
S5100	Adult Daycare Services 15Min	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S5101	Adult Day Care Per Half Day	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S5102	Adult Day Care Per Diem	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
	· · · · · · · · · · · · · · · · · · ·	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
S5105 S5108	Centerbased Day Care Perdiem Homecare Train Pt 15 Min	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S5109		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	
	Homecare Train Pt Session	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S5110	Family Homecare Training 15M	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S5111	Family Homecare Train/Sessio	service review.	-	-	-	-
S5115	Nonfamily Homecare Train/15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5116	Nonfamily Hc Train/Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5120	Chore Services Per 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5121	Chore Services Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-

S5125	Attendant Care Service /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S5126	Attendant Care Service / Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5130	Homaker Service Nos Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5131	Harrison for the New /Plan	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.				
33131	Homemaker Service Nos /Diem	Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
S5135	Adult Companioncare Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5136	Adult Companioncare Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
S5140	Adult Foster Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S5141	Adult Foster Care Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S5145	Child Fostercare Th Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S5146	Ther Fostercare Child /Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
S5150	Unskilled Respite Care /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S5151	Unskilled Respitecare / Diem	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
S5160	Emer Response Sys Instal&Tst	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			<u> </u>	
S5161	Emer Rspns Sys Serv Permonth	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
S5162	Emer Rspns System Purchase	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-			-
S5165	Home Modifications Per Serv	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-		-
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	-
S5170	Homedelivered Prepared Meal	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-		-
S5175	Laundry Serv Ext Prof /Order	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
S5181	Hh Respiratory Thrpy Nos/Day	contract/clinical review.	-	-	_	-
S5185	Med Reminder Serv Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S5497	Hit Cath Care Noc	Unlisted: Procedure/service not specifically defined or classified Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RAD601.038	Imaging (MSI)		_
S8130	Interferential Current Stimulator 2 Channel	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.041	Interferential Current Stimulation	-	-
S8131	Interferential Current Stimulator 4 Channel	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	-	-
S8189	Trach Supply Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
S8270	Enuresis Alarm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S8301	Infect Control Supplies Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
S8460	Camisole Post-Mast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S8930	Auricular Electrostimulation	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.019	Cranial Electrotherapy Stimulation and Auricular		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Electrostimulation		_
S8940	Hippotherapy Per Session	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.022	Hippotherapy	-	-
S8948	Low-Level Laser Trmt 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR702.005 MED201.045 MED205.022	Acne Management Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence Low-Level and High-Power Laser Therapy Treatment of Tinnitus	-	-
S8990	Pt Or Manip For Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9001	Home Uterine Monitor With Or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB401.017	Home Uterine Activity Monitoring	-	-
S9056	Coma Stimulation Per Diem	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MEDOOF 014	Concern Stimulation for Comp Dationts		
39036	coma stimulation Per Diem	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED2U5.U14	Sensory Stimulation for Coma Patients	-	-
S9090	Vertebral Axial Decompressio	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Non-Surgical Spinal Decompression Traction Devices	-	-
S9117	Back School Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	THE803.024	Back School	_	_
S9125	Respite Care In The Home P	service review.	-	Polls Hamadishala 1997 B. C.	-	-
S9335	Ht Hemodialysis Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	_
S9379	Hit Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
S9381	Hit High Risk/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S9436	Lamaze Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
S9437	Childbirth Refresher Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9439	Vbac Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S9442	Birthing Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S9444	Parenting Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S9445	Pt Education Noc Individ	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
S9446	Pt Education Noc Group	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_	_	_
50447		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S9447	Infant Safety Class	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9449	Weight Mgmt Class	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9451	Exercise Class	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9454	Stress Mgmt Class	service review.	=	-	-	-

1		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
S9472	Cardiac Rehabilitation Progr	predetermination to avoid post-service reviewe.	THE803.023	Cardiac Rehabilitation (CR)	_	_
S9482	Family Stabilization 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9542	Ht Inj Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
S9558	Ht Inj Growth Horm Diem	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PY501 040	Human Growth Hormone (GH)		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
S9562	Ht Inj Palivizumab Diem	predetermination to avoid post-service review.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	_	
S9810	Ht Pharm Per Hour	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S9900	Christian Sci Pract Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S9970	Health Club Membership Yr	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S9975	Transplant Related Per Diem	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	_
S9976	Lodging Per Diem	service review.	SUR703.001	_	_	_
		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S9977	Meals Per Diem	service review.	SUR703.001	-	-	-
59981	Med Record Copy Admin	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S9982	Med Record Copy Per Page	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9986	Not Medically Necessary Svc	service review.	-	-	-	_
S9988	Serv Part Of Phase I Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S9990	Services Provided As Part Of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
59991	Services Provided As Part Of	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	_	_
S9992	Transportation Costs To And	service review.	-	-	-	_
S9994	Lodging Costs (E.G. Hotel Ch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	_
S9996	Meals For Clinical Trial Par	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
59999	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
T1014	Telehealth Transmit Per Min	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			1/1/2021	
		service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	1/1/2021	_
T1505	Elec Med Comp Dev Noc	contract/clinical review.	-	-	-	_
T1999	Noc Retail Items Andsupplies	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
T2012	Habil Ed Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
T2013	Habil Ed Waiver Per Hour	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
T2014	Habit Barrer Walter Bar B	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		-		
	Habil Prevoc Waiver Per D	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	_
T2015	Habil Prevoc Waiver Per Hr	contract/clinical review.	-	-	-	-
T2016	Habil Res Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
T2017	Habil Res Waiver 15 Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	_	_
T2018	Habil Sup Empl Waiver/Diem	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-		_
T2019						
	Habil Sup Empl Waiver 15Min	contract/clinical review.	-	-	-	-
T2020	Day Habil Waiver Per Diem	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	<u>-</u>	-
T2020 T2021		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	- -	- -	- - -	- - -
	Day Habil Waiver Per Diem	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	- - -	-	- - -	- - -
T2021 T2024	Day Habil Waiver Per Diem Day Habil Waiver Per 15 Min Serv Asmnt/Care Plan Waiver	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	- - -	- - -	- - -
T2021 T2024 T2025	Day Habil Waiver Per Diem Day Habil Waiver Per 15 Min Serv Asmnt/Care Plan Waiver Waiver Service Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	- - - -	- - -	- - -
T2021 T2024	Day Habil Waiver Per Diem Day Habil Waiver Per 15 Min Serv Asmnt/Care Plan Waiver	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	- - - -	- - - -	- - - -
T2021 T2024 T2025	Day Habil Waiver Per Diem Day Habil Waiver Per 15 Min Serv Asmnt/Care Plan Waiver Waiver Service Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.			- - - - -	- - - - -
T2021 T2024 T2025 T2026	Day Habil Walver Per Diem Day Habil Walver Per 15 Min Serv Asmnt/Care Plan Walver Walver Service Nos Special Childcare Walver/D	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.			-	- - - - - -
T2021 T2024 T2025 T2026 T2027	Day Habil Walver Per Diem Day Habil Walver Per 15 Min Serv Asmnt/Care Plan Walver Walver Service Nos Special Childcare Walver/D Spec Childcare Walver 15 Min	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-		- - - - -	- - - - - -
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V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_		_
		service review.				
V2744	Tint Photochromatic Lens/Es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review.	-	-		-
V2787	Astigmatism-Correct Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature		
*2707	Astiginatism-correct runction	predetermination to avoid post-service review.	301713.023	Telescope (IMT)	_	-
V2788	Presbyopia-Correct Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature		
12700	r resbyopia-correct runction	predetermination to avoid post-service review.	301713.023	Telescope (IMT)		-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	OTH903.012			
V2799	Misc Vision Item Or Service	service review.	DME104.003		_	_
		Unlisted: Procedure/service not specifically defined or classified	DIVIE104.003			
V5090	Handan Ald Diagonian For	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V3090	Hearing Aid Dispensing Fee	contract/clinical review.	-	-	-	-
V5095	Implant Mid Ear Hearing Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear		
V3093		predetermination to avoid post-service review.		Hearing Aids	-	-
VE267	Hearing Aid Sup/Access/Dev	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V5267		contract/clinical review.	-	-	-	-
1/5274		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V5274	Ald Unspecified	contract/clinical review.	-	-	-	-
V5287	Ald Sou (Doe Doorbook No.	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V3207	Ald Fm/Dm Receiver Nos	contract/clinical review.	-	-	-	-
VE 200		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V5298	Hearing Aid Noc	contract/clinical review.	-	-	-	-
\r. 200		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V5299	Hearing Service	contract/clinical review.	-	-	-	-
1/5262		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
V5362	Speech Screening	predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
V5363	I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DCV204 044	A. ±' C± D'± (ACD)		
VJJUJ	Language Screening	predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	-	-