



**Predetermination, Post-Service Review and Non-Covered  
2022 Commercial Benefit Procedure Code List**  
**Posted August 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/>

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	<a href="#">Procedures/services reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.</a> Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	<a href="#">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).</a>
Unlisted or Undefined	Procedures/services not specifically defined or classified, maybe subject to contract/clinical review.

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

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

Code	Code Description	Code Group & Description	Medical Policy No.	Medical Policy Title	Effective Date	Ending Date
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	10/1/2021	-
11200	Removal Of Skin Tags <W/15	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	-
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
11920	Correct Skin Color 6.0 Cm/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11921	Correct Skin 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.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11950	Tx Contour Defects 1 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11951	Tx Contour Defects 1.1-5.0Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11952	Tx Contour Defects 5.1-10Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11954	Tx Contour Defects >10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11960	Insert Tissue Expander(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 SUR716.011 RX501.063	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery Compounded Drug Products	-	-
11980	Implant Hormone Pellet(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 RX501.007 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies	-	-
15758	Free Fascial Flap Microvasc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Nonpharmacologic Treatment of Rosacea	-	-

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	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15782	Dermabrasion Other Than Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001 THE801.030	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15783	Dermabrasion Suprflr 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	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15786	Abrasion Lesion Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15787	Abrasion Lesions Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001 SUR717.001	Acne Management Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15788	Chemical Peel Face Epiderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.018 SUR717.001 THE801.030	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15789	Chemical Peel Face Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Nonpharmacologic 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	Acne Management Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15820	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15821	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15822	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Surgery with Related Services	-	-
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 Surgery with Related Services	-	-
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	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Sites	-	-
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 Surgery with Related Services	-	-
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 Lipedema 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	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15833	Excise Excessive Skin Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15834	Excise Excessive Skin Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15835	Excise Excessive Skin Buttkc	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	-	-
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 Surgery for Lipedema and Lymphedema Surgical Treatment of Gynecomastia	-	-
15847	Exc Skin Abd Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR701.024	Cosmetic and Reconstructive Procedures Surgery for Lipedema and Lymphedema	-	-
15876	Suction Lipiectomy 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	-	-
15877	Suction Lipiectomy Trunk	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	-	-
15878	Suction Lipiectomy Upjr Extrem	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	-	-
15879	Suction Lipiectomy Lwr Extrem	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	-	-
15999	Removal Of Pressure Sore	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
17106	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17107	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17108	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17340	Cryotherapy Of Skin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE801.028	Acne Management	-	-
17360	Skin Peel Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028	Acne Management	-	-
17380	Hair Removal By Electrolysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
17999	Skin Tissue Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	-	-
19300	Removal Of Breast Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.017	Surgical Treatment of Gynecomastia	-	-
19303	Mast Simple Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.015	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Risk-Reducing (Prophylactic) Mastectomy	-	-
19316	Suspension Of Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR716.010 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Mastopexy Reconstructive Breast Surgery	-	-

19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR716.001 SUR717.001 SUR716.011 SUR716.012	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery Reduction Mammoplasty	–	–
19325	Breast Augmentation W/Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–
19328	Rmvl Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–
19330	Rmvl Ruptured Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–
19340	Insj Breast Implt Sm D Mast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR717.001 SUR716.011	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–
19342	Insj/Rplcmt Brst Implt Sep D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR717.001 SUR716.011	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–
19350	Breast Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	–	–
19355	Correct Inverted Nipple(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	–	–
19357	Tiss Xpndr Plmt Brst Rcnstj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	–	–
19371	Peri-Implt Capsic Brst Compl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	–	–
19499	Breast Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR716.021 SUR701.037 SUR701.031 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Reconstructive Breast Surgery	–	–
20527	Insj Dupuytren Cord W/Enzyme	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	–	–
20560	Ndl Insj W/O Nix 1 Or 2 Musc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	–	–
20561	Ndl Insj W/O Nix 3+ Musc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	–	–
20983	Ablate Bone Tumor(S) Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	–	–
20985	Cptr-Asst Dir Ms Px	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	–	–
20999	Musculoskeletal Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
21073	Mnpj Of Tmj W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016 SUR705.010	Manipulation Under Anesthesia Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
21089	Prepare Face/Oral Prosthesis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
21120	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
21121	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
21122	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR705.030 SUR706.009 SUR716.011	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
21123	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR705.030 SUR706.009 SUR705.010	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
21125	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery	–	–
21127	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR705.030 SUR706.009	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management	–	–
21145	Lefort I-1 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)	–	–
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)	–	–
21147	Lefort I-3/+ 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)	–	–
21150	Lefort II Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21151	Lefort II W/Bone Grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21154	Lefort III W/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21159	Lefort III W/Fhdw/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21188	Reconstruction Of Midface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21208	Augmentation Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	–	–
21248	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
21249	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
21299	Cranio/Maxillofacial Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
21499	Head Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
21685	Hyoid Myotomy & Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	–	–
21899	Neck/Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
22505	Manipulation Of Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	–	–
22586	Prescl Fuse W/ Instr L5-S1	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.038	Axial Lumbosacral Interbody Fusion	–	–
22899	Spine Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
22999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
23929	Shoulder Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.032	Shoulder Resurfacing	–	–

24300	Manipulate Elbow W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	–	–
25999	Forearm Or Wrist Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
26340	Manipulate Finger W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	–	–
26341	Manipul Palm Cord Post Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	–	–
26989	Hand/Finger Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
27275	Manipulation Of Hip Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 require Prior Authorization per contract agreement.	SUR705.033	Sacroiliac Joint Fusion or Stabilization	–	–
27299	Pelvis/Hip Joint Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement until 04/01/2022.	SUR702.017 SUR705.019 SUR705.036 SUR705.029	Facet Joint and Sacroiliac Joint Denervation Hip Resurfacing (HR) Surgery for Groin Pain in Athletes Surgical Treatment of Femoroacetabular Impingement (FAI)	–	–
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 contract/clinical review.	–	–	–	–
27702	Reconstruct Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.021	Total Ankle Replacement (TAR)	–	6/30/2022
27703	Reconstruction Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 contract/clinical review.	–	–	–	–
28446	Osteochondral Talus Autograft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.020	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	–	–
28890	Hi Enrgy Eswt Plantar Fascia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	–	–
28899	Foot/Toes Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
29440	Addition Of Walker To Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
29799	Casting/Strapping Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
29862	Hip Arthro W/Debridement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	6/30/2022
29866	Autgraft Implnt Knee W/Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.020 SUR705.035	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	–	–
29868	Meniscal Trnspl Knee W/Scpe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.	SUR705.034	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 04/01/2022.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	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	Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	–
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.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	–
29999	Arthroscopy Of Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.029 SUR705.041 SUR705.024	Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulectomy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartamental Arthritis of the Knee	–	–
30400	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30410	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30420	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30430	Revision Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30435	Revision Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30450	Revision Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	–	–
30468	Rpr Nsl Vlv Collapse W/Implt	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 CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.017	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	2/15/2021	5/14/2021
30468	Rpr Nsl Vlv Collapse W/Implt	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 CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.017	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	5/15/2021	–
30999	Nasal Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	SUR706.001	–	–	–
31299	Sinus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	SUR706.019 SUR706.001	–	–	–
31599	Larynx Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
31647	Bronchial Valve Init Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.015	Bronchial Valves	–	6/30/2022
31648	Bronchial Valve Remov Init	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.015	Bronchial Valves	–	6/30/2022
31649	Bronchial Valve Remov Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.015	Bronchial Valves	–	6/30/2022
31651	Bronchial Valve Addl Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.015	Bronchial Valves	–	6/30/2022
31899	Airways Surgical Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
32994	Ablate Pulm Tumor Perq Crybl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Rfl	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 contract/clinical review.	–	–	–	–
33211	Insert Card Electrodes Dual	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	–	–
33213	Insert Pulse Gen Dual Leads	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
33225	L Ventr 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
33274	Tcat Insg/Rpl Perm Ldis 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 Ldis 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	Insg 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 Systems)	–	–
33286	Rmvl Subq Car Rhythm Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	–	3/31/2021
33289	Tcat Impl Wrts P-Art Prs Snr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	–	6/30/2022
33542	Removal Of Heart Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.026	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 contract/clinical review.	SUR707.026 SUR701.009 SUR703.027	Cardiac Restoration and Remodeling Procedures Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	–	–
36299	Vessel Injection Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
36465	Nlx Noncprnd Scrsnt 1 Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36466	Nlx Noncprnd Scrsnt 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	Nlx Scrsnt Spider Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36470	Nlx Scrsnt 1 Incmrpt Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36471	Nlx Scrsnt Mlt Incmrpt Vn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36473	Endovenous Mchnchem 1St Vein	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	–	–
36474	Endovenous Mchnchem Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	–	–
36475	Endovenous Rf 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36478	Endovenous Laser 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36479	Endovenous Laser Vein Addon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
36482	Endoven Ther Chem Adhes 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	THE801.026	Extracorporeal Photopheresis (ECP)	–	6/30/2022
37215	Transcath Stent Cca W/Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–
37216	Transcath Stent Cca W/O Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–
37217	Stent Placemt Retro Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–
37218	Stent Placemt Ante Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.028	Extracranial Carotid Angioplasty or Stenting	–	–
37241	Vasc Embolize/Occlude Venous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–
37242	Vasc Embolize/Occlude Artery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–
37243	Vasc Embolize/Occlude Organ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.047 SUR701.015 THE801.022	Radioembolization for Primary and Metastatic Tumors of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions Transcatheter Arterial Chemoembolization (TACE) of the Liver	–	–
37244	Vasc Embolize/Occlude Bleed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	–	–
37500	Endoscopy Ligate Perf Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37501	Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
37700	Revise Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37722	Ligate/Strip Long Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37735	Removal Of Leg Veins/Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37760	Ligate Leg Veins Radical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37765	Stab Phleb Veins Xtr 10-20	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37766	Phleb Veins - Extrem 20+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37780	Revision Of Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
37799	Vascular Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
38129	Laparoscope Proc Spleen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
38204	BI Donor Search Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)	–	–
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.039	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.029	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.034	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.033	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias		
			SUR703.040	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.042	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.035	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.032	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.031	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.030	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		
			SUR703.046	Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis		
			SUR703.044	Hematopoietic Cell Transplantation for Solid Tumors in Children		
			SUR703.050	Hematopoietic Cell Transplantation for Waldenström Macroglobulinemia		
			SUR703.045	Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors		



38205	Harvest Allogeneic Stem Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38206	Harvest Auto Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38207	Cryopreserve Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38208	Thaw Preserved Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-

38209	Wash Harvest Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38210	T-Cell Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38211	Tumor Cell Deplete Of Harvst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
38212	Rbc Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-

38213	Platelet Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)		
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	-	-
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		
38214	Volume Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)		
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	-	-
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		
38215	Harvest Stem Cell Concentrate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)		
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	-	-
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		
38230	Bone Marrow Harvest Allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)		
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	-	-
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		
38232	Bone Marrow Harvest Autolog	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)		
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	-	-
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome		



38240	Transplt Allo Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	—	—
38241	Transplt Autol Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	—	—
38242	Transplt Allo Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	—	—
38243	Transply Hematopoietic Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	—	—
38308	Incision Of Lymph Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.024	Surgery for Lipedema and Lymphedema	—	—
38589	Laparoscope Proc Lymphatic	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
38999	Blood/Lymph System Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
39499	Chest Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
39599	Diaphragm Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
40799	Lip Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
40899	Mouth Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
41530	Tongue Base Vol Reduction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.021 SUR706.009	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver Sleep Related Breathing Disorders: Surgical Management	—	—
41599	Tongue And Mouth Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
41820	Excision Gum Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—	—
41821	Excision Of Gum Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—	—
41822	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	—	—	—	—

41823	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41828	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41830	Removal Of Gum Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41870	Gum Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41872	Repair Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41874	Repair Tooth Socket	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
41899	Dental Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
42145	Repair Palate Pharynx/Uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	–	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 Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–
43210	Egd Esophagoastric Endoplysty	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
43236	Uppr Gi Scope W/Submuc Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003 RX501.019 MED201.016	Bariatric Surgery Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD)	–	–
43252	Egd Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–
43253	Egd Us Transmural Injxn/Mark	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
43257	Egd W/Thrmr 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 Sphinctr Agmntj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)	–	–
43289	Laparoscope Proc Esoph	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	–	6/30/2022
43499	Esophagus 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.	MED201.016 SUR709.033	–	–	–
43633	Removal Of Stomach Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43644	Lap Gastric Bypass/Roux-En-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43659	Laparoscope Proc Stom	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
43770	Lap Place Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43771	Lap Revise Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43772	Lap Rmvl Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43773	Lap Replace Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43774	Lap Rmvl Gastr Adj All Parts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43775	Lap Sleeve Gastrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43843	Gastroplasty W/O V-Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43845	Gastroplasty Duodenal Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43846	Gastric Bypass For Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43847	Gastric Bypass Incl Small I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43848	Revision Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43886	Revise Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43887	Remove Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43888	Change Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	–	–
43999	Stomach Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
44238	Laparoscope Proc Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
44705	Prepare Fecal Microbiota	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 contract/clinical review.	–	–	–	–
45499	Laparoscope Proc Rectum	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
45999	Rectum Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
46707	Repair Anorectal Fist W/Plug	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR709.032	Plugs for Fistula Repair	–	–
46999	Anus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
47370	Laparo Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	–	–
47382	Percut Ablate Liver Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.038 SUR709.029	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	–	–
47399	Liver Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
47579	Laparoscope Proc Biliary	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
47999	Bile Tract Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. 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.	–	–	–	–
49329	Laparo Proc Abdm/Per/Oment	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
49659	Laparo Proc Hernia Repair	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–

49999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
50250	Cryoablate Renal Mass Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR703.007 SUR703.008 SUR703.013	Kidney Transplant Liver Transplant and Combined Liver-Kidney Transplant Pancreas and Related Organ Tissue 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 predetermination to avoid post-service review.	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	–	–
50593	Perc Cryo Ablate Renal Tum	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	–	–
50949	Laparoscope Proc Ureter	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
51715	Endoscopic Injection/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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/Add 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	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	–	–
53899	Urology Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
54125	Removal Of Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–
54200	Treatment Of Penis Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders 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	–	–
54400	Insert Semi-Rigid Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	–	–
54401	Insert Self-Contd Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	–	–
54405	Insert Multi-Comp Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	–	–
54660	Revision Of Testis	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 Surgery with Related Services	–	–
54699	Laparoscope Proc Testis	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
55559	Laparo Proc Spermatic Cord	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
55706	Prostate Saturation Sampling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.015	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, including Comprehensive 3D Mapping with Biopsy	–	6/30/2022
55880	Abtlj Ml 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	–
55899	Genital Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement until 04/01/2022.	SUR717.014 SUR701.031 SUR710.019	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Nerve Graft With Radical Prostatectomy	–	–
55970	Sex Transformation M To F	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–
55980	Sex Transformation F To M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	–	–
56810	Repair Of Perineum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	–	–
57291	Construction Of Vagina	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	–	–
57292	Construct Vagina With Graft	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	–	–
57335	Repair Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	–	–
57426	Revise Prosth Vag Graft Lap	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	–	–
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.	–	–	–	–
58674	Laps Abtlj Uterine Fibroids	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.033	Laparoscopic, Percutaneous and Transcervical 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 contract/clinical review.	–	–	–	–
58997	Fetal Invas Px W/U	<del>MP Criteria: Procedure/service reviewed against Medical Criteria.</del> Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	–	6/30/2022
59898	Laparo Proc Ob Care/Deliver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
59899	Maternity Care Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
60659	Laparo Proc Endocrine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
60699	Endocrine Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
61630	Intracranial Angioplasty	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.064 SUR701.027	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–
61635	Intracran Angioplasty W/Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.064 SUR701.027	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–
61645	Perq Art M-Thrombect &/Nfs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	6/30/2022
61650	Evasc Pring Admn Rx Agnt 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–
61651	Evasc Pring Admn Rx Agnt Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	–
61850	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR712.025 SUR712.039 SUR714.009	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy Auditory Brainstem Implant	–	–
61863	Implant Neuroelectrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR712.025 SUR712.039 SUR714.009	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy Auditory Brainstem Implant	–	–
61864	Implant Neuroelectrde Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR712.025 SUR712.039	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy	–	–
62263	Epidual Lysis Mult Sessions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR712.024	Lysis of Epidural Adhesions	2022-05-01	2022-07-31
62263	Epidual Lysis Mult Sessions	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.024	Lysis of Epidural Adhesions	2022-08-01	–
62264	Epidual Lysis On Single Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR712.024	Lysis of Epidural Adhesions	2022-05-01	2022-07-31
62264	Epidual Lysis On Single Day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.024	Lysis of Epidural Adhesions	2022-08-01	–

64561	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	–	–
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	–	–
64582	Opn Mplltj Hgglsl Nstrm Ary Pg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	2022-05-01	–
64628	Trml Dstrjtj Ios 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
64628	Trml Dstrjtj Ios Bvn 1St 2 L/S	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-08-01	–
64629	Trml Dstrjtj Ios Bvn Ea Addl	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 Dstrjtj Ios Bvn Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-08-01	–
64640	Injection Treatment Of Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.040	Ablation of Peripheral Nerves to Treat Pain	5/15/2021	–
64999	Nervous System Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.019 SUR703.003 SUR702.017 RX504.015 SUR712.024 SUR701.031 MED205.037 SUR710.019 SUR712.033 MED205.032 MED205.035 MED205.036 MED205.039 MED201.039	–	–	–
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 predetermination to avoid post-service review.	OTH903.030	Keratoprosthesis	–	–
65785	Impljtj Ntrstrml Crnl Rng Seg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.031	Implantation of Intrastromal Corneal Ring Segments	–	–
66174	Translum Dil Eye Canal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.032	Viscocalanostomy and Canaloplasty	–	–
66175	Trnslum Dil Eye Canal W/Stnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.032	Viscocalanostomy and Canaloplasty	–	–
66179	Aqueous Shunt Eye W/O Graft	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	–	–
66180	Aqueous Shunt Eye W/Graft	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	5/1/2021	–
66183	Insert Ant Drainage Device	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	–	–
66989	Xcpsl Ctrc Rmvl Cplx Insj 1+	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	2022-03-15	–
66991	Xcapsl Ctrc Rmvl Insj 1+	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	2022-03-15	–
66999	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
67299	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
67399	Unlisted Px Extraocular Musc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
67599	Orbit Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
67900	Repair Brow Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, 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.	SUR716.004	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.	SUR716.004	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	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 predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	–	–
69399	Outer Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
69705	Nps Surg Dilat Eust Tube Uni	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.018	Balloon Dilatation of the Eustachian Tube	1/15/2021	–
69706	Nps Surg Dilat Eust Tube Bi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.018	Balloon Dilatation of the Eustachian Tube	1/15/2021	–
69714	Implant Temple Bone W/Stimul	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 Bone Implant 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 require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	12/31/2021
69799	Middle Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
69930	Implant Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	–	–
69949	Inner Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
69979	Temporal Bone Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
76496	Fluoroscopic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
76497	Ct Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
76498	Mri Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
76499	Radiographic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
76999	Echo Examination Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
77299	Radiation Therapy Planning	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
77399	External Radiation Dosimetry	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
77499	Radiation Therapy Management	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
77799	Radium/Radioisotope Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–

78099	Endocrine Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78199	Blood/Lymph Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78299	GI Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78399	Musculoskeletal Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78499	Cardiovascular Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78599	Respiratory Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78699	Nervous System Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78799	Genitourinary Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
78999	Nuclear Diagnostic Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
79999	Nuclear Medicine Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
80299	Quantitative Assay Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
81099	Urinalysis Test Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
81422	Fetal Chromol Microdeltj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	Moved to PA list	10/1/2019
81479	Unlisted Molecular Pathology	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	MED208.089	–	–	–
81599	Unlisted Maa	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
82523	Collagen Crosslinks	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	–	–
83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.158	Molecular Testing For Chronic Heart Failure and Heart Transplant	–	–
83695	Assay Of Lipoprotein(A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–
83698	Assay Lipoprotein Pla2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	–	–
83701	Lipoprotein Bld Hr Fraction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–
83704	Lipoprotein Bld Quan Part	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–
83722	Lipoprtn Dir Meas Sd Ldl Chl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–
83937	Assay Of Osteocalcin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	–	–
83987	Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.024	Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders	–	–
84112	Eval Amniotic Fluid Protein	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	–	–
84431	Thromboxane Urine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.148	Measurement of Thromboxane Metabolites in Urine	–	–
84999	Clinical Chemistry Test	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
85999	Hematology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
86001	Allergen Specific Igg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001	Allergy Management	–	–
86343	Leukocyte Histamine Release	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001	Allergy Management	–	–
86352	Cell Function Assay W/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	MED207.088	Intracellular Micronutrient Analysis	–	–
86486	Skin Test Nos Antigen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
86849	Immunology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
86910	Blood Typing Paternity Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
86911	Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
86950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)	–	–
			SUR703.002	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)		
			SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.047	Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.038	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.029	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)		
			SUR703.034	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
			SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer		
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias		
			SUR703.042	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas		
			SUR703.032	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)		
86999	Transfusion Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas	–	–
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, including Multiple Myeloma (MM) and POEMS Syndrome		
			SUR703.044	Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis		
			SUR703.045	Hematopoietic Cell Transplantation for Solid Tumors in Children		
			SUR703.050	Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia		
			SUR703.045	Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors		
			–	–		
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			–	–		
87505	Nfct Agent Detection Gi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	–	–
87506	Iadna-Dna/Rna Probe Tq 6-11	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	–	–
87507	Iadna-Dna/Rna Probe Tq 12-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	–	–
87797	Detect Agent Nos Dna Dir	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
87798	Detect Agent Nos Dna Amp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
87799	Detect Agent Nos Dna Quant	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
87899	Agent Nos Assay W/Optic	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
87999	Microbiology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–



88000	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88005	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88007	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88012	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88014	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88016	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88020	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88025	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88027	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88028	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88029	Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88036	Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88037	Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88040	Forensic Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88045	Coroners Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
88099	Necropsy (Autopsy) Procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	–	–
88199	Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
88299	Cytogenetic Study	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
88375	Optical Endomicroscopy Interp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–
88399	Surgical Pathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
88749	In Vivo Lab Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
89240	Pathology Lab Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
89258	Cryopreservation Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
89259	Cryopreservation Sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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.	–	–	–	–
89398	Unlisted Reprod Med Lab Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
90283	Human Ig Iv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	PSY301.014	Autism Spectrum Disorders (ASD)	–	–
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])	–	–
90378	Rsv Mab Im 50Mg	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])	–	–
90399	Immune Globulin	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	–	–
90584	Dengue Vacc Quad 2 Dose Subq	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	7/1/2022	–
90689	Vacc Iiv4 No Prsrv 0.25MI Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
90749	Vaccine Toxoid	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
90867	Tcranial Magn Stim Tx Plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	–	–
90868	Tcranial Magn Stim Tx Deli	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	–	–
90869	Tcran Magn Stim Redetermine	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	–	–
90875	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	–	–
90876	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	–	–
90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.001	Hypnosis	–	6/30/2022
90880	Hypnotherapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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.	–	–	–	–
90901	Biofeedback Train Any Meth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	–	–
90912	Bfb Training 15t 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 Biofeedback as a Treatment of Urinary Incontinence	4/1/2021	–
90913	Bfb Training Ea Addl 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.017 PSY301.016	Biofeedback as a Treatment of Fecal Incontinence or 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 predetermination to avoid post-service review.	MED201.005	Esophageal pH Monitoring	–	–
91065	Breath Hydrogen/Methane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.161	Hydrogen or Methane Breath Testing	–	–
91110	GI Tract Capsule Endoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon	–	–
91111	Esophageal Capsule Endoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	–	–
91112	GI Wireless Capsule Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	–	–
91117	Colon Motility 6 Hr Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.017	Gastrointestinal (GI) Motility Measurement	–	–
91132	Electrogastrography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	–	–
91133	Electrogastrography W/Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	–	–
91299	Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
92015	Determine Refractive State	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92065	Orthoptic/Pleoptic Training	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92132	Cmpttr Ophth Dx Img Ant Segmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.021	Optical Coherence Tomography of the Anterior Eye Segment	–	–
92145	Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.031	Corneal Hysteresis	–	–
92340	Fit Spectacles Monofocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92341	Fit Spectacles Bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92342	Fit Spectacles Multifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92354	Fit Spectacles Single System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92355	Fit Spectacles Compound Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92370	Repair & Adjust Spectacles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
92499	Eye Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
92512	Nasal Function Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED204.004	Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry	–	–
92517	Vemp Test I&R Cervical	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
92517	Vemp Test I&R Cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	5/15/2021	–
92518	Vemp Test I&R 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
92518	Vemp Test I&R Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	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
92519	Vemp Tst I&R Cervical&Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	5/15/2021	–
92546	Sinusoidal Rotational Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.047	Vestibular Function Testing	–	–
92548	Cdp-Sot 6 Cond W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	–	–
92549	Cdp-Sot 6 Cond W/I&R Mct&Adt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	–	–
92640	Aud Brainstem Implt Program	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 Policy (CPCP).	MED202.070	Non-Invasive Measurement of Central Blood Pressure (cBP)	–	–
93228	Remote 30 Day Ecg Rev/Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	–	–
93229	Remote 30 Day Ecg Tech Supp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	–	–
93660	Tilt Table Evaluation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.048	Tilt Table Testing	–	–
93702	Bis Xtracell Fluid Analysis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.036	Bioimpedance Devices for Detection and Management of Lymphedema	–	–
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.014	Thermography	–	–
93797	Cardiac Rehab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	–	–
93798	Cardiac Rehab/Monitor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	–	–
93799	Cardiovascular Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
93998	Noninvas Vasc Dx Study Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
94014	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–
94015	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–
94016	Review Patient Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	–	–
94452	Hast W/Report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
94453	Hast W/Oxygen Titrate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
94799	Pulmonary Service/Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
95060	Eye Allergy Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	–	–

95065	Nose Allergy Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	–	–
95199	Allergy Immunology Services	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
95700	Eeg Cont Rec W/Vid Eeg Tech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95705	Eeg W/O Vid 2-12 Hr Unmnt	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	–	–
95706	Eeg Wo Vid 2-12Hr Intmt Mnt	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	–	–
95707	Eeg W/O Vid 2-12Hr Cont Mnt	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	–	–
95708	Eeg Wo Vid Ea 12-26Hr Unmnt	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	–	–
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	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95710	Eeg W/O Vid Ea 12-26Hr Cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95711	Veeg 2-12 Hr Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95712	Veeg 2-12 Hr Intmt Mnt	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	–	–
95713	Veeg 2-12 Hr Cont Mnt	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	–	–
95714	Veeg Ea 12-26 Hr Unmnt	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 Mnt	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 Mnt	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 Electroencephalogram	–	–
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	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95719	Eeg Phys/Qhp Ea Incr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95720	Eeg Phy/Qhp Ea Incr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95721	Eeg Phy/Qhp>36-60 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95722	Eeg Phy/Qhp>36-60 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95723	Eeg Phy/Qhp>60-84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95724	Eeg Phy/Qhp>60-84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95725	Eeg Phy/Qhp>84 Hr W/O Vid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95726	Eeg Phy/Qhp>84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	–	–
95803	Actigraphy Testing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.048	Actigraphy	–	–
95905	Motor &/ Sens Nrv Cndg Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033	Automated Point-of-Care Nerve Conduction Testing	–	–
95954	Eeg Monitoring/Giving Drugs	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	–	–
95957	Eeg Digital Analysis	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	–	–
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	Intraoperative Neurophysiologic Monitoring (IONM) 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	Autism Spectrum Disorders (ASD)	–	–
95966	Meg Evoked Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.038 PSY301.014	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD)	–	–
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.	–	–	–	–
96000	Motion Analysis Video/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	–	–
96001	Motion Test W/Flt Press Meas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	–	–
96002	Dynamic Surface Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009 MED205.006	Gait Analysis Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	–	–
96003	Dynamic Fine Wire Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 contract/clinical review.	–	–	–	–
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 predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	–	–
96922	Laser Tx Skin >500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 THE801.033	Acne Management Phototherapy for Dermatologic Conditions	–	–
96931	Rcm Celulr Subcelulr Img Skin	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	–	–
96932	Rcm Celulr Subcelulr Img Skin	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	–	–
96933	Rcm Celulr Subcelulr Img Skin	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	–	–
96934	Rcm Celulr Subcelulr Img Skin	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	–
96935	Rcm Celulr Subcelulr Img Skin	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 Celulr Subcelulr Img Skin	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 Egm 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-service review.	–	–	–	–
97533	Sensory Integration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 THE803.020	Autism Spectrum Disorders (ASD) Sensory Integration Therapy and Auditory Integration Therapy	–	–
97537	Community/Work Reintegration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Policy (CPCP).	DME101.044	Ultrasound Wound Therapy	–	–
97799	Physical Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99024	Postop Follow-Up Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99026	In-Hospital On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99027	Out-Of-Hosp On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99050	Medical Services After Hrs	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99056	Med Service Out Of Office	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99058	Office Emergency Care	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99070	Special Supplies Phys/Qhnp	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, may be subject to contract/clinical review.	–	–	–	–
99080	Special Reports Or Forms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99082	Unusual Physician Travel	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99183	Hyperbaric Oxygen Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	PSY301.014	Autism Spectrum Disorders (ASD)	–	–
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-service review.	–	–	1/1/2021	–
99449	Ntrprof Ph1/Ntrnet/Ehr 31/>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	1/1/2021	–
99450	Basic Life Disability Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99451	Ntrprof Ph1/Ntrnet/Ehr 5/>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	1/1/2021	–
99452	Ntrprof Ph1/Ntrnet/Ehr Rfrl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	1/1/2021	–
99453	Rem Mntr Physiol Param Setup	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99454	Rem Mntr Physiol Param Dev	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99455	Work Related Disability Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99456	Disability Examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99457	Rem Physiol Mntr 1st 20 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99491	Chnrc Care Mgmt Svc 30 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
99499	Unlisted E&M Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
99600	Home Visit Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
0052U	Lpoptn Bld W/5 Maj Classes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	–	–
0054T	Bone Srgy Cmptr Fluor Image	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	–	–
0055T	Bone Srgy Cmptr Ct/Mri Imag	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	–	–
0062U	Al Sle Igg&Igm Alys 80 Bmrk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.159	Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases	–	–
0063U	Neuro Autism 32 Amines Alg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014	Autism Spectrum Disorders (ASD)	–	–
0066U	Pamg-1 Ia Cervico-Vag Fluid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	–	–
0075T	Perq Stent/Chest Vert Art	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	–	–
0076T	S&I Stent/Chest Vert Art	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	–	–
0084U	Rbc Dna Gnotyp 10 Bld Groups	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0086U	Nfct Ds Bact&Fng Org Id 6+	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0087U	Crđ Hrt TrnspI Mrna 1283 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0088U	TrnspIj Kdn Algrft Rej 1494	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0089U	Onc Minma Frame & Linc00518	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0090U	Onc Cutan Minma Mrna 23 Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0091U	Onc Clrct Scr Whl Bld Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0092U	Onc Lng 3 Prtn Bmrk Plsm Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0093U	Rx Mntr 6S Com Drugs Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0094U	Genome Rapid Sequence Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0095U	Inflm Ee Elisa Alys Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0096U	Hpv HI Risk Types Male Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0097U	Gi Pathogen 22 Targets	Non Covered: Procedure/service may not covered by the Plan. Procedure/service reviewed against Medical Policy Criteria.	–	–	–	–
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 Policy (CPCP).	SUR713.026	Retinal Prosthesis	–	–

0100U	Respir Pathogen 20 Targets	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	3/31/2021
0101T	Extracorp Shockvw Tx Hi Enrg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	–	–
0101U	Hered Colon Ca Do 15 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0102T	Extracorp Shockvw Tx Anesth	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	–	–
0102U	Hered Brst Ca Rltd Do 17 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0103U	Hered Ova Ca Pnl 24 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0105U	Neph Cld Mult Eclia Tum Nec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0106T	Touch Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	–	–
0106U	Gstr Emptg 7 Timed Brth Spec	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.017	Gastrointestinal (GI) Motility Measurement	–	–
0107T	Vibrate Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	–	–
0107U	C Diff Tox Ag Detcj Ia Stool	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0108T	Cool Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	–	–
0108U	GI Barrett Esoph 9 Prtn Bmrk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0109T	Heat Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	–	–
0109U	Id Aspergillus Dna 4 Species	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0110T	Nos Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	–	–
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0111U	Onc Colon Ca Kras&Nras Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0112U	Iadi 165&185 Rrna Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0113U	Onc Prst8 Pca3&Tmprss2-Erg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0114U	GI Barretts Esoph Vim&Ccn1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0115U	Respir Iadna 18 Viral&2 Bact	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0116U	Rx Mntr Nzm Ia 35+Oral Flu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0117U	Pain Mgmt 11 Endogenous Anal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0118U	Trnspj Don-Drv Cll-Fr Dna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0119U	CrD Ceramides Liq Chrom Plsm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0120U	Onc B Cll Lymphm Mrna 58 Gen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
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 Wbl Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0123U	Mchnl Fragility Rbc Prflg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0129U	Hered Brst Ca Rltd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0130U	Hered Colon Ca Do Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0131U	Hered Brst Ca Rltd Do Pnl 13	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0132U	Hered Ova Ca Rltd Do Pnl 17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0133U	Hered Prst8 Ca Rltd Do 11	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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-service review.	–	–	–	–
0138U	Brc1 Brc2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0139U	Neuro Austm Meas 6 C Metablt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014	Autism Spectrum Disorders (ASD)	–	9/30/2021
0140U	Nfct Ds Fungl Dna 15 Trgt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0141U	Nfct Ds Bact&Fng Gram Pos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0142U	Nfct Ds Bact&Fng Gram Neg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0143U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0144U	Drug Assay 160+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0145U	Drug Assay 65+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0146U	Drug Assay 80+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0147U	Drug Assay 85+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0148U	Drug Assay 100+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0149U	Drug Assay 60+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0150U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0151U	Nfct Bct/Vir Resp Nfctj 33	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	3/31/2022
0152U	Nfct Ds Dna Untgtg 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 Plk3Ca Gene	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–



0156U	Copy Number Sequence Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0157U	Apc Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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-service review.	–	–	–	–
0162U	Hered Colon Ca Trgt Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
0191T	Insert Ant Segment Drain Int	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	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 Policy (CPCP).	OTH903.022	Ophthalmologic Techniques For Evaluating Glaucoma	–	–
0202T	Post Vert Arthrpst 1 Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.034	Facet Arthroplasty	–	–
0207T	Clear Eyelid Gland W/Heat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	–	–
0219T	Plmt Post Facet Implt Cerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	–	–
0220T	Plmt Post Facet Implt Thor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	–	–
0221T	Plmt Post Facet Implt Lumb	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	–	–
0222T	Plmt Post Facet Implt Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	–	–
0232T	Njx Platelet Plasma	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	–	–
0253T	Insert Aqueous Drain Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	–	–
0263T	Im B1 Mrw Cel Ther Cmpl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	–	–
0264T	Im B1 Mrw Cel Ther Xcl Hrvt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	–	–
0265T	Im B1 Mrw Cel Ther Hrvt Onl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	–	–
0278T	Tempr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	–	–
0312T	Laps Impltj Nstim Vagus	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	–
0313T	Laps Rmvl Nstim Array Vagus	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	–
0314T	Laps Rmvl Vgl Arry&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	–
0315T	Rmvl Vagus Nerve 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	–
0316T	Replc Vagus Nerve 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	–
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 Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	–	–
0331T	Heart Symp Image Plnr	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	Insj Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	–	–
0338T	Trnscth Renal Symp Denrv Unl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	–	–
0339T	Trnscth Renal Symp Denrv Bil	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	–	–
0347T	Ins Bone Device For Rsa	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	–	–
0348T	Rsa Spine Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	–	–
0349T	Rsa Upper Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	–	–
0350T	Rsa Lower Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	–	–
0352T	Oct Brst/Node I&R Per Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Policy (CPCP).	RAD601.045	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA)	–	–
0376T	Insert Ant Segment Drain Int	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	–	12/31/2021
0378T	Visual Field Assmnt Rev/Rprt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	–	–
0379T	Vis Field Assmnt Tech Suppt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	–	–
0397T	Ercp W/Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	–	–
0398T	Mrgfus Strtctc Les Abtlj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.022	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)	–	–
0402T	Colgn Cross-Link Crn Med Sep	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
0423T	Assay Secretory Type II Pla2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	–	12/31/2021
0424T	Insj/Rplc Nstim Apnea Cmpl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	–

0425T	Insj/Rplc Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0426T	Insj/Rplc Nstim Apnea Strm 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	—
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 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	—
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 Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0433T	Repos Nstim Apnea Sensing Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0434T	Interro Eval Nggs Apnea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0435T	Pgrmrg Eval Nggs Apnea 1 Ses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0436T	Pgrmrg Eval Nggs Apnea Study	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	—
0444T	1St Plmt Drug Elut Oc Ins	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.035	Drug-Eluting Intracranial Punctal Plugs and Ocular Inserts	—	—
0445T	Sbsqt Plmt Drug Elut Oc Ins	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.035	Drug-Eluting Intracranial Punctal Plugs and Ocular Inserts	—	—
0449T	Insj Aqueous Drain Dev 1St	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	—	—
0450T	Insj Aqueous Drain Dev Each	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	—	—
0464T	Visual Ep Test For Glaucoma	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.033	Visual Evoked Potential Testing for Glaucoma	—	—
0465T	Supchrdl Nix Rx W/O Supply	EIU: Procedure/service not reimbursed 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	—	—
0466T	Insj Ch Wal Respir Eltrd/Ra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	—	12/31/2021
0470T	Oct Skin Img Acquis I&R 1St	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	—
0471T	Oct Skin Img Acquis 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	Pgrmrg 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	Reprgrmrg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	—	—
0474T	Insj Aqueous Drg Dev Io Rsvr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	—	—
0479T	Fxj Abl Lsr 1St 100 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	4/1/2021	—
0480T	Fxj Abl Lsr Ea Addl 100sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	4/1/2021	—
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/Utr! 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 Glnid 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	EyeIeld 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.036	Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	2/15/2021	5/14/2021
0509T	Pattern Erg W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.036	Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	5/15/2021	—
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 Hlg Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	—	—
0524T	Ev Cath Dir Chem Abtlj 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 DI 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	—	—
0548T	Tprml Balo Cntnc Dev Bi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	—	12/31/2021
0549T	Tprml Balo Cntnc Dev Uni	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	—	12/31/2021
0550T	Tprml Balo Cntnc Dev Rmvl Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	—	12/31/2021

0551T	Tprnl Balo Cntnc Dev Adjmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	–	12/31/2021
0563T	Evac Meibomian Gland Heat Bi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	CPCP028	Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU)	–	–
0565T	Autol Cell Implt Adps Hrvng	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
0565T	Autol Cell Implt Adps Hrvng	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	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.	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).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	8/15/2021	–
0587T	Perq Implt/Rplcmt Isdms 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	–
0588T	Revision/Removal Isdms 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 predetermination to avoid post-service review.	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	–
0590T	Elec Alys Cplx Prgrmg lins	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	–
0602T	Transdermal Gfr Measurements	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	–
0603T	Transdermal Gfr Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	–
0615T	Eye Mvmt Alys W/O Calbrj I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	–
0620T	Evasc Ven Artiz Tib/Pnrl Vn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0621T	Trabeculostomy Interno Laser	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0622T	Trabeculostomy Int Lsr W/Scp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0623T	Auto Quantification C Plaque	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	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 Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0625T	Auto Quan C Plaq Cptr Alys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0626T	Auto Quan C Plaq I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	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 Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0628T	Perq Njx Algc Fluor Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0629T	Perq Njx Algc Ct Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0630T	Perq Njx Algc Ct Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0631T	Tc Vis Lit Hysperspectral Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0632T	Perq Tcat Us Abljt Nrv P-Art	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0639T	Wrls Skn Snr Anisotropy Meas	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	–
0640T	Ncntc Nr Ifr Sptcsrc Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	–
0641T	Ncntc Nr Ifr Sptcsrc Wnd Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	–
0642T	Ncntc Nr Ifr Sptcsrc Wnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	–
0643T	Tcat L Ventr Rstrj Dev Implt	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	7/1/2021	–
0645T	Tcat Impltj C Sins Rdcjtj Dev	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	7/1/2021	–
0646T	Tlvt/Rplcmt W/Prstc Viv Perq	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	7/1/2021	–
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	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	7/1/2021	–
0656T	Vrt Bdy Tethering Ant <7 Seg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	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 Policy (CPCP).	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	7/1/2021	–
0658T	Elec Impd Spectrsc 1+5kn Les	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	–
0664T	Don Hysterectomy Open Cdv	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
0664T	Don Hysterectomy Open Cdv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	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
0665T	Don Hysterectomy Open Liv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–
0666T	Don Hysterectomy Laps 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 Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–
0667T	Don Hysterectomy Rcp Uter	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
0667T	Don Hysterectomy Rcp Uter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–
0668T	Bkbench Prep Don Uter Algrft	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
0668T	Bkbench Prep Don Uter Algrft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–

0669T	Bkbench Rcnstj Don Uter Ven	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
0669T	Bkbench Rcnstj Don Uter Ven	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–
0670T	Bkbench Rcnstj Don Uter Artl	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
0670T	Bkbench Rcnstj Don Uter Artl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	–
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.	ADM1001.005	Ambulance and Transport Services	2014-09-15	–
A0430	Fixed Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	ADM1001.005	Ambulance and Medical Transport Services	–	–
A0431	Rotary Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	–	–
A0435	Fixed Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	ADM1001.005	Ambulance and Medical Transport Services	–	–
A0436	Rotary Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	–	–
A0888	Noncovered Ambulance Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	–	–
A0999	Unlisted Ambulance Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A2001	Innovamatrix Ac Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-15	–
A2002	Mirrangen adv wnd mat per sq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/15/2022	4/14/2022
A2002	Mirrangen adv wnd mat per sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	4/15/2022	–
A2004	Xcellistem 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	1/15/2022	4/14/2022
A2004	Xcellistem per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	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.	SUR704.011	Amniotic Membrane and Amniotic Fluid	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).	SUR704.011	Amniotic Membrane and Amniotic Fluid	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.	SUR704.011	Amniotic Membrane and Amniotic Fluid	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).	SUR704.011	Amniotic Membrane and Amniotic Fluid	4/15/2022	–
A2007	Restrata 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	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 Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	4/15/2022	–
A2008	Theragenesis 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	1/15/2022	4/14/2022
A2008	Theragenesis per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	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.	SUR704.011	Amniotic Membrane and Amniotic Fluid	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).	SUR704.011	Amniotic Membrane and Amniotic Fluid	4/15/2022	–
A2010	Apis per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	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).	SUR704.011	Amniotic Membrane and Amniotic Fluid	4/15/2022	–
A2011	Supra Sdrm Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2022	–
A2012	Suprathel Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2022	–
A2013	Innovamatrix Fs Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2022	–
A4100	Skin Sub Fda Cld As Dev Nos	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2022	–
A4267	Male Condom	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	12/31/2022
A4290	Sacral Nerve Stim Test Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	–	–
A4335	Incontinence Supply	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A4421	Ostomy Supply Misc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A4458	Reusable Enema Bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4520	Incontinence Garment Anytype	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4553	Nondisp Underpads All Sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4554	Disposable Underpads	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4555	Ca Tx E-Stim Electr/Transduc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	–	–
A4575	Hyperbaric O2 Chamber Disps	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). PA maybe required until 04/01/2022.	PSY301.014 THE801.003	Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy	–	–
A4600	Sleeve Inter Limb Comp Dev	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	–	–
A4639	Infrared HT Sys Replcmnt Pad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	–	–
A4641	Radiopharm Dx Agent Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A4649	Surgical Supplies	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A4890	Repair/Maint Cont Hemo Equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4913	Misc Dialysis Supplies Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A4927	Non-Sterile Gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4931	Reusable Oral Thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A4932	Reusable Rectal Thermometer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A5507	Modification Diabetic Shoe	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A6000	Wound Warming Wound Cover	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	–	–

A6261	Wound Filler Gel/Paste /Oz	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A6262	Wound Filler Dry Form / Gram	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A6512	Compres Burn Garment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A6549	G Compression Stocking	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9150	Misc/Exper Non-Prescript Dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A9152	Single Vitamin Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	–	–
A9153	Multi-Vitamin Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified	–	–	–	–
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A9273	Hot/Cold Bottle/Cap/Col/Wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
A9279	Monitoring Feature/Devisenoc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9280	Alert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9282	Wig Any Type	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
A9282	Wig any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. 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 Policy (CPCP).	DME103.001	Orthotics	–	–
A9291	Pres Digital Behav Thera Fda	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY302.002	Digital Health Therapies for Substance Abuse	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 predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	–
A9579	Gad-Base Mr Contrast Nos 1ml	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9597	Pet Dx For Tumor Id Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9598	Pet Dx For Non-Tumor Id Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9698	Non-Rad Contrast Materialnoc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9699	Radiopharm Rx Agent Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9900	Supply/Accessory/Service	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
A9999	Dme Supply Or Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
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 Othrrws C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
C1052	Hemostatic Agent Gi Topic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	2/1/2021	5/14/2021
C1052	Hemostatic Agent Gi Topic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	–
C1761	Cath Trans Intra Litho/Coro	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	2021-07-01	–
C1764	Event Recorder Cardiac	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 Systems)	–	–
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 Unicompartamental Arthritis of the Knee	–	–
C1783	Ocular Imp Aqueous Drain De	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	–	–
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.030	Keratoprosthesis	–	–
C1823	Gen Neuro Trans Sen/Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	–
C1825	Gen Neuro Carot Sinus Baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.034	Baroreflex Stimulation Devices	2/1/2021	–
C1833	Cardiac Monitor Sys	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 Systems)	2022-01-01	–
C1841	Retinal Prosth Int/Ext Comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	–	–
C1842	Retinal Prosth 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).	SUR713.026	Retinal Prosthesis	–	–
C1889	Implant/Insert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
C2623	Cath Translumin Drug-Coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.041 SUR701.028 SUR701.027	Endovascular Therapies for Extracranial Vertebral Artery Disease Extracranial Carotid Angioplasty or Stenting Intracranial Stenting or Angioplasty, including Endovascular Procedures	–	6/30/2022
C2624	Wireless Pressure Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	–	–
C2698	Brachytx Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
C2699	Brachytx Non-Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
C9072	Inj Imm Glob Ascenv	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
C9073	Brexucabtagene Autoleucl 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	–
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	–
C9097	Inj faricimab-svoa 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.044	Faricimab-svoa	7/1/2022	–
C9257	Bevacizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	OTH903.027 OTH903.020 OTH903.015	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions 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 (Surigimend 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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	4/1/2021	–
C9360	Surigimend Neonatal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	–	–
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 review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	4/1/2021	–
C9363	Integra Meshed Bil Wound Mat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	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	–	–
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.	RX501.087 RX501.099 RX501.110	–	–	–
C9739	Cystoscopy Prostatic Imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift	–	–
C9740	Cysto Impl 4 Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift	–	–
C9757	Spine/Lumbar Disk Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.045	Annulus Closure After Discectomy	2022-05-01	2022-07-31
C9757	Spine/Lumbar Disk Surgery	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.045	Annulus Closure After Discectomy	2022-08-01	–
C9764	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	–
C9765	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, And Transluminal Stent Placement(S), Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	–
C9766	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy And Atherectomy, Includes Angioplasty Within The Same Vessel(S). When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	–
C9767	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S), And Atherectomy, Includes Angioplasty Within The Same Vessel(S). When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	–
C9768	Endo U-Guide Hep Porto Grad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.043	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	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.	MED201.025	Temporary Prostatic Stent	–	–
C9770	Vitrectomy, Mechanical, Pars Plana Approach, With Subretinal Injection Of Pharmacologic/Biologic Agent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	4/1/2021	–
C9771	Nsl/Sins Cryo Post Nasal Tis	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).	SUR706.001	Nasal and Sinus Surgery	2/1/2021	5/14/2021
C9771	Nsl/Sins Cryo Post Nasal Tis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.001	Nasal and Sinus Surgery	5/15/2021	–
C9772	Revasc lithotrip tib/perone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	8/14/2021
C9772	Revasc lithotrip tib/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	–
C9773	Revasc lithot-stent tib/per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	8/14/2021
C9773	Revasc lithot-stent tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	–
C9774	Revasc lithot-ather tib/per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	8/14/2021
C9774	Revasc lithot-ather tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	–
C9775	Revasc lith-sten-ath tib/per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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 Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	–
C9777	Esophag Mucosal Integ Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	EIU Procedures/Services	8/15/2021	–
C9898	Inpnt Stay Radiolabeled Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
C9899	Inpnt Implant Pros Dev No Cov	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D0999	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D1705	AstraZeneca Covid-19 vaccine administration #first dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	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 Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D2999	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
D3999	Unspecified Endodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D4999	Unspecified Periodontal Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D5899	Unspecified Removable Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–

D7210	Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D7999	Unspecified Oral Surgery Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D8210	Removable Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D8999	Unspecified Orthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D9999	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0210	Electric Heat Pad Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0217	Water Circ Heat Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0218	Fluid Circ Cold Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	-	-
E0231	Wound Warming Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0232	Warming Card For Nwt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0236	Pump For Water Circulating P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0240	Bath/Shower Chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0241	Bath Tub Wall Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0242	Bath Tub Rail Floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0243	Toilet Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0244	Toilet Seat Raised	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0247	Trans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0248	Hdtrans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0273	Bed Board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0274	Over-Bed Table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0300	Enclosed Ped Crib Hosp Grade	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	-	-
E0315	Bed Accessory Brd/Tbl/Support	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0316	Bed Safety Enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	-	-
E0446	Topical O2 Deliver Sys Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0471	Rad W/Backup Non Inv Intrfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	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 Breathing Disorders	-	-
E0486	Oral Device/Appliance Cusfab	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 Breathing Disorders	-	-
E0487	Electronic Spirometer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	-	-
E0616	Cardiac Event Recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
E0625	Patient Lift Bathroom Or Toi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0635	Patient Lift Electric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0637	Combination Sit To Stand Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0641	Multi-Position Stnd Fram Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0650	Pneuma Compressor 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	-	-
E0651	Pneum Compressor Segmental	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	-	-
E0652	Pneum Compres W/Cal Pressure	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	-	-
E0655	Pneumatic Appliance Half Arm	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	-	-
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	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0657	Segmental Pneumatic Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0660	Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0665	Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0666	Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0667	Seg Pneumatic Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0668	Seg Pneumatic Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0669	Seg Pneumatic Appl Half Leg	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	-	-
E0670	Seg Pneum Int Legs/Trunk	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	-	-
E0671	Pressure Pneum Appl Full Leg	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	-	-
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	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0673	Pressure Pneum Appl Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0675	Pneumatic Compression Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-

E0676	Inter Limb Compress Dev Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	–	–
E0691	Uvl Pnl 2 Sq Ft Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	–	–
E0692	Uvl Sys Panel 4 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	–	–
E0693	Uvl Sys Panel 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	–	–
E0694	Uvl Md Cabinet Sys 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	–	6/30/2022
E0740	Non-Implant Pelv Flr E-Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.037 MED201.030	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence Sexual Dysfunctions, Assessment and Treatment	–	–
E0745	Neuromuscular Stim For Shock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018 MED201.026	Sacral Nerve Neuromodulation/Stimulation Surface Electrical Stimulation	–	–
E0747	Elec Osteogen Stim Not Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.044	Electrical Bone Growth Stimulation of the Appendicular 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	–	–
E0749	Elec Osteogen Stim Implanted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.013 SUR705.044	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures Electrical Bone Growth Stimulation of the Appendicular Skeleton	–	–
E0760	Osteogen Ultrasound Stimlor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.030	Low Intensity Pulsed Ultrasound Fracture Healing Device	–	–
E0761	Nontherm Electromgntc Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	–	–
E0762	Trans Elec JT Stim Dev Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.042	Electrical Stimulation for the Treatment of Arthritis	–	–
E0764	Functional Neuromuscularstim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.033	Functional Neuromuscular Electrical Stimulation	1/1/2022	3/31/2022
E0764	Functional Neuromuscularstim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.033	Functional Neuromuscular Electrical Stimulation	–	6/30/2021
E0764	Functional Neuromuscularstim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.033	Functional Neuromuscular Electrical Stimulation	4/1/2022	–
E0766	Elec Stim Cancer Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	–	–
E0769	Electric Wound Treatment Dev	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	–	–
E0770	Functional Electric Stim Nos	Unlisted: Procedure/service not specifically defined or classified. MP Criteria: Procedure/service reviewed against Medical Criteria.	MED201.033	Functional Neuromuscular Electrical Stimulation	–	–
E0830	Ambulatory Traction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041	Pneumatic Traction and Spinal Unloading Devices	–	–
E0840	Tract Frame Attach Headboard	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0849	Cervical Pneum Trac Equip	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	–	–
E0850	Traction Stand Free Standing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0855	Cervical Traction Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0856	Cervic Collar W Air Bladders	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	–	–
E0860	Tract Equip Cervical Tract	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0890	Traction Frame Attach Pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0935	Cont Pas Motion Exercise Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.023	Continuous Passive Motion (CPM) Device	–	6/30/2022
E0936	Cpm Device Other Than Knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.023	Continuous Passive Motion (CPM) Device	–	–
E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	–	–
E0985	W/C Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1003	Pwr Seat Recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1004	Pwr Seat Recline Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1005	Pwr Seat Recline Pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1006	Pwr Seat Combo W/O Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1012	Ctr Mount Pwr Elev Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1161	Manual Adult Wc W Tiltspace	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E1229	Pediatric Wheelchair Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
E1230	Power Operated Vehicle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	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 predetermination to avoid post-service review.	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	2022-01-01	–
E1632	Wearable artificial kidney	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	7/1/2022	12/31/2022
E1632	Wearable artificial kidney	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	1/1/2023	–

E1699	Dialysis Equipment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
E1700	Jaw Motion Rehab System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
E1701	Repl Cushions For Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
E1702	Repl Mearr Scales Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	–	–
E1902	Aac Non-Electronic Board	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 DME104.009	Autism Spectrum Disorders (ASD) Speech Generating Devices (SGD)	–	–
E2300	Pwr Seat Elevation Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2301	Pwr Standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2310	Electro Connect Btw Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2311	Electro Connect Btw 2 Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2312	Mini-Prop Remote Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2313	Pwc Harness Expand Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2325	Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2326	Breath Tube Kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2327	Head Control Interface Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2328	Head/Extremity Control Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2330	Head Control Proximity Switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2331	Attendant Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2343	W/C Dpth 22-25 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2351	Electronic Sgd Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2373	Hand/Chin Ctrl Spec Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2377	Expandable Controller Initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
E2500	Sgd Digitized Pre-Rec <=8Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	–	–
E2508	Sgd Spelling Phys Contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	–	–
E2510	Sgd W Multi Methods Msg/Accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	–	–
E2511	Sgd Sftwre Prgm 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	Sgd Accessory Noc	MP Criteria: Procedure/service reviewed against Medical Criteria. 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 predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	–	–
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	–	–	–	–
G0255	Current Percep Threshold Tst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033 MED205.030	Automated Point-of-Care Nerve Conduction Testing Quantitative Sensory Testing	–	–
G0276	Pild/Placebo Control Clin Tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	–	–
G0281	Elec Stim Unattend For Press	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	–	–
G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	–	–
G0293	Non-Cov Surg Proc Clin Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G0294	Non-Cov Proc Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G0295	Electromagnetic Therapy Onc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	–	–
G0329	Electromagntic Tx For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	–	–
G0341	Percutaneous Islet Celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	–	–
G0416	Prostate Biopsy Any Mthd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.015	Saturation Biopsy for Diagnosis, Staging and 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 predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	–	–

G0423	Intens Cardiac Rehab No Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	–	–
G0428	Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). PA maybe required until 04/01/2022.	SUR705.034	Meniscal Allografts and Other Meniscal Implants	–	–
G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	–	–
G0455	Fecal Microbiota Prep Instil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	–	–
G0465	Autolog Prp Diab Wound Ulcer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	4/13/2021	3/31/2022
G0465	Autolog Prp Diab Wound Ulcer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	4/1/2022	–
G2011	Alcohol/Sub Misuse Assess	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G2082	Visit Esketamine 56M Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	–	4/15/2021
G2082	Visit esketamine 56m or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	08/01/2021	–
G8395	Lvef>=40% Doc Normal Or Mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8396	Lvef Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8397	Dil Macula/Fundus Exam/W Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8399	Pt W/Dxa Results Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8400	Pt W/Dxa No Results Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8404	Low Externity Neur Exam Docum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8405	Low Externity Neur Not Perfor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8410	Eval On Foot Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8415	Eval On Foot Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8416	Pt Inelig Footwear Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8417	Calc Bmi Abv Up Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8418	Calc Bmi Blw Low Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8419	Calc Bmi Out Nrm Param Nof/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8420	Calc Bmi Norm Parameters	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8421	Bmi Not Calculated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8422	Pt Inelig Bmi Calculation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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-service review.	–	–	–	–
G8432	Dep Scr Not Doc Rng	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8433	Scr For Dep Not Cpt Doc Rsn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8450	Beta-Bloc Rx Pt W/Abn Lvef	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8451	Pt W/Abn Lvef Inelig B-Bloc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8452	Pt W/Abn Lvef B-Bloc No Rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8465	High Risk Recurrence Pro Ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8473	Ace/Arb Thxpy Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8474	Ace/Arb Not Rx?D; Doc Reas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8475	Ace/Arb Thxpy Not Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8476	Bp Sys <140 And Dias <90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8477	Bp Sys>=140 And/Or Dias >=90	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8478	Bp Not Performed/Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8482	Flu Immunize Order/Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8483	Flu Imm No Admin Doc Rea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G8484	Flu Immunize No Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
G9050	Oncology Work-Up Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9051	Oncology Tx Decision-Mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9052	Onc Surveillance For Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9053	Onc Expectant Management Pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9054	Onc Supervision Palliative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9055	Onc Visit Unspecified Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9056	Onc Prac Mgmt Adheres Guide	Unlisted: Procedure/service not specifically defined or classified	–	–	–	–
G9057	Onc Pract Mgmt Differs Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9058	Onc Prac Mgmt Disagree W/Gui	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9059	Onc Prac Mgmt Pt Opt Alterna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–



G9060	Onc Prac Mgmt Dif Pt Comorb	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9061	Onc Prac Cond Noadd By Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9062	Onc Prac Guide Differs Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9063	Onc Dx Nscl Stgl No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9064	Onc Dx Nscl Stg2 No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9065	Onc Dx Nscl Stg3A No Progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9066	Onc Dx Nscl Stg3B-4 Metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9067	Onc Dx Nscl Dx Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9068	Onc Dx Scic/Nscl Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9069	Onc Dx Scic/Nscl Ext At Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9070	Onc Dx Scic/Nscl Ext Unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9071	Onc Dx Brst Stg1-2B Hr Nopro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9072	Onc Dx Brst Stg1-2 Noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9073	Onc Dx Brst Stg3-Hr No Pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9074	Onc Dx Brst Stg3-Noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9075	Onc Dx Brst Metastatic/ Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9077	Onc Dx Prostate T1No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9078	Onc Dx Prostate T2No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9079	Onc Dx Prostate T3B-T4Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9080	Onc Dx Prostate W/Rise Psa	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9083	Onc Dx Prostate Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9084	Onc Dx Colon T1-3 N1-2 No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9085	Onc Dx Colon T4 NO W/O Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9086	Onc Dx Colon T1-4 No Dx Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9087	Onc Dx Colon Metas Evid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9088	Onc Dx Colon Metas Noevid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9089	Onc Dx Colon Extent Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9090	Onc Dx Rectal T1-2 No Progr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9091	Onc Dx Rectal T3 N0 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9092	Onc Dx Rectal T1-3 N1-2Noprg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9093	Onc Dx Rectal T4 N M0 No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9094	Onc Dx Rectal M1 W/Mets Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9095	Onc Dx Rectal Extent Unknwn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9096	Onc Dx Esophag T1-T3 Noprogr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9097	Onc Dx Esophageal T4 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9098	Onc Dx Esophageal Mets Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9099	Onc Dx Esophageal Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9100	Onc Dx Gastric No Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9101	Onc Dx Gastric P R1-R2Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9102	Onc Dx Gastric Unresectable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9103	Onc Dx Gastric Recurrent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9104	Onc Dx Gastric Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9105	Onc Dx Pancreat P R0 Res No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9106	Onc Dx Pancreat P R1/R2 No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9107	Onc Dx Pancreatic Unresectab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9108	Onc Dx Pancreatic Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9109	Onc Dx Head/Neck T1-T2No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9110	Onc Dx Head/Neck T3-4 Noprogr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9111	Onc Dx Head/Neck M1 Mets Rec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9112	Onc Dx Head/Neck Ext Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9113	Onc Dx Ovarian Stg1A-B No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9114	Onc Dx Ovarian Stg1A-B Or 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9115	Onc Dx Ovarian Stg3/4 Noprogr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9116	Onc Dx Ovarian Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9117	Onc Dx Ovarian Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9123	Onc Dx Cml Chronic Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9124	Onc Dx Cml Acceler Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9125	Onc Dx Cml Blast Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9126	Onc Dx Cml Remission	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9128	Onc Dx Multi Myeloma Stage I	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9129	Onc Dx Mult Myeloma Stg2 Hig	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9130	Onc Dx Multi Myeloma Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–

G9131	Onc Dx Brst Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9132	Onc Dx Prostate Mets No Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9133	Onc Dx Prostate Clinical Met	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9134	Onc Nhlstg 1-2 No Relap No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9135	Onc Dx Nhl Stg 3-4 Not Relap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9136	Onc Dx Nhl Trans To Lg Bcell	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9137	Onc Dx Nhl Relapse/Refractor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9138	Onc Dx Nhl Stg Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9139	Onc Dx Cml Dx Status Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9140	Frontier Extended Stay Demo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9147	Outpatient Intravenous Insulin Treatment (OIVt) Either Pulsatile Or Continuous, By Any Means, Guided By The Results Of Measurements For:Respiratory Quotient; And/Or, Urine Urea Nitrogen (Uun); And/Or, Arterial, Venous Or Capillary Glucose; And/Or Potassium Concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	–	–
G9978	Remote E/M New Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9979	Remote E/M New Pt 20Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9980	Remote E/M New Pt 30 Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9981	Remote E/M New Pt 45Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9982	Remote E/M New Pt 60Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9983	Remote E/M Est. Pt 10Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9984	Remote E/M Est. Pt 15Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9985	Remote E/M Est. Pt 25Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9986	Remote E/M Est. Pt 40Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
G9987	Bpci Advanced In Home Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
H0046	Mental Health Service Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
H0047	Alcohol/Drug Abuse Svc Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
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 predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	–
J0129	Abatacept Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.113 RX501.096	Abatacept Specialty Medication Administration Site of Care	–	–
J0172	Inj. Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.137	Aducanumab-avwa	1/1/2022	–
J0180	Agalsidase Beta 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	–	–
J0202	Injection Alemtuzumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.077	Alemtuzumab	–	–
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	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	–	–
J0221	Injection Alglucosidase Alfa (Lumzyme) 10 Mg	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	–	–
J0222	Inj. Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	–	–
J0223	Inj Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.125 RX501.096	Givosiran Specialty Medication Administration Site of Care	–	–
J0224	Inj. Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.133	Lumasiran	2021-07-01	–
J0256	Alpha 1 Proteinase Inhibitor	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J0291	Inj. Plazomicin 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	–
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	Inj Anifrolumab-Fnia 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.138	Anifrolumab-fnia	2022-04-01	–
J0517	Inj. Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.100 RX501.096	Benralizumab Specialty Medication Administration Site of Care	–	–
J0565	Inj. Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.093	Bezlotoxumab	–	–
J0567	Inj. Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 require Prior Authorization per contract agreement.	RX502.058 RX501.096	Burosumab-twza Specialty Medication Administration Site of Care	–	–
J0586	AbobotulinumtoxinA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.019 MED201.014	Botulinum Toxin 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	–
J0598	C-1 Esterase Cinryze	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 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	–	–
J0775	Collagenase Clostr Hist Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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 predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	–
J0881	Darbepoetin Alfa Non-Esrd	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 require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	–	12/31/2021
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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	–
J1096	Dexametha Oph Insert 0.1 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

J1097	Phenylep Ketorolac Oph 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	Eccallantide 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 Eccallantide 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 Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.095 RX501.096	Edaravone Specialty Medication Administration Site of Care	-	-
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 predetermination to avoid post-service review.	RX501.136	Evinacumab-dgnb	10/1/2021	-
J1306	Injection inclisiran 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.142	Inclisiran	7/1/2022	-
J1322	Elosulfase Alfa 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	-	-
J1325	Epoprostenol 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	-	-
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	Viltolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.129	Viltolarsen	5/1/2021	-
J1428	Inj Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.084	Eteplirsen	-	-
J1429	Inj Golodirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	-	-
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	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
J1551	Inj cutaquig 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [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	-
J1555	Inj Cuvitrux 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	-	-
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	-	-
J1557	Injection, Immune Globulin, (Gammagex), 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	-	-
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	-	-
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	-	-
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	-	-
J1562	Vivaglobin Inj	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])	-	-
J1566	Immune Globulin Powder	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	-	-
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	-	-
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	-	-
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	-	-
J1575	Hyqvia 100Mg Immunoglobulin	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	-	-
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])	-	-
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 Capoaot Nos	Unlisted. Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J1743	Idursulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
J1745	Infliximab Not Biosimil 10Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.028 RX501.051 RX501.096	Acne Management Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
J1746	Inj. Ibalizumab-Uyk 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.099 RX501.096	Ibalizumab-uyk Specialty Medication Administration Site of Care	-	-
J1786	Imuglucerase 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	-	-
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	-
J1931	Laronidase 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	-	-
J1943	Inj. Aristada Initio 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	-
J1944	Aripazole Lauroxil 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	-
J1951	Inj Fensolvi 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	2021-07-01	-
J2182	Injection Mepolizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.080 RX501.096	Mepolizumab Specialty Medication Administration Site of Care	-	-
J2278	Ziconotide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, 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	-	-
J2326	Inj Nusinersen 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.086	Nusinersen	-	-
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 predetermination to avoid post-service review.	RX501.143	Tezepelumab-ekko	7/1/2022	-
J2357	Omaliuzumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.058 RX501.096	Omaliuzumab Specialty Medication Administration Site of Care	-	-
J2440	Papaverin Hcl Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	-
J2502	Inj Pasireotide Long Acting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.079	Pasireotide	-	-
J2503	Pegaptanib Sodium Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.027 OTH903.020 OTH903.015	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Photodynamic Therapy (PDT) for Choroidal 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
J2778	Ranibizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.027 OTH903.020 OTH903.015	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	-	-
J2779	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	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 Ophth=3MI	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	-
J2840	Inj Sebelipase Alfa 1 Mg	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	-	-

J2860	Injection Situximab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	Moved to PA list	–
J3031	Inj. Fremezumab-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	–	–
J3060	Inj. Taliglucerase Alfa 10 U	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	–	–
J3111	Inj. Romosozumab-Aqgg 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 Testosterone Replacement Therapies	–	–
J3241	Inj. Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.110	Specialty Medication Administration Site of Care Teprotumumab	–	–
J3245	Inj. Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.123	Specialty Medication Administration Site of Care Tildrakizumab-asmn	–	–
J3262	Tocilizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, 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 Pamotate	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 Human Growth Hormone (GH)	–	–
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	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	–	–
J3385	Velaglucerase Alfa	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	–	–
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-Vjkb	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	–	–
J3398	Inj Luxturna 1 Billion Vec G	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	–	–
J3399	Inj Onase Abepar-Xioi Treat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.104	Onasemnogene Abeparovvec-xioi	–	–
J3490	Drugs Unclassified Injection	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	MED206.001 RX501.063 SUR716.001 RX501.105 RX501.087 RX501.040 RX501.099 OTH903.027 OTH903.020 RX504.015 RX501.080 SUR706.001 RX501.086 RX501.085 RX501.104 RX502.030 MED206.006 RX501.110 MED201.014 RX501.040	–	–	–
J3520	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.008	Chelation Therapy	–	–
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.073 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.085 RX501.104 RX501.110	–	–	–
J3591	Esrd On Dialysi Drug/Bio Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7177	Inj. Fibrlyga 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibrlyga)	–	–
J7178	Inj Human Fibrinogen Con Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibrlyga)	–	–
J7192	Factor VIII Recombinant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7195	Factor IX Recombinant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7199	Hemophilia Clot Factor Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7309	Methyl Aminolevulinate Top	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.027	Dermatologic Applications of Photodynamic Therapy (PDT)	–	–
J7314	Inj. Yutliq 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 Ocrlplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.026	Ocrlplasmin 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 predetermination to avoid post-service review.	OTH903.024	Intravitreal, Punctum, and Intracameral Implants	–	6/30/2022
J7401	Mometasone Furoate Sinus Imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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).	RX501.063	Compounded Drug Products	–	–
J7615	Levalbuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7622	Beclomethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7624	Betamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–

J7627	Budesonide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7628	Bitolterol Mesylate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7629	Bitolterol Mesylate Comp 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	–	–
J7632	Cromolyn Sodium Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7634	Budesonide Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7635	Atropine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7636	Atropine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7637	Dexamethasone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7638	Dexamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7640	Formoterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7641	Flunisolide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7642	Glycopyrrolate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7643	Glycopyrrolate Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7645	Ipratropium Bromide Comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7647	Isoetharine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7650	Isoetharine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7657	Isoproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7660	Isoproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7667	Metaproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7670	Metaproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7676	Pentamidine Comp Unit Dose	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7680	Terbutaline Sulf Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7681	Terbutaline Sulf Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7683	Triamcinolone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7684	Triamcinolone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7685	Tobramycin Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	–	–
J7699	Inhalation Solution For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7799	Non-Inhalation Drug For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J7999	Compounded Drug Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J8498	Antiemetic Rectal/Supp Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J8499	Oral Prescrip Drug Non Chemo	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J8597	Antiemetic Drug Oral Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J8999	Oral Prescription Drug Chemo	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J9020	Asparaginase Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
J9022	Inj Atezolizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9023	Injection Avelumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	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 require Prior Authorization per contract agreement.	OTH903.027 OTH903.020 OTH903.015	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	–	12/31/2021
J9037	Injection, Belantamab Mafodotin-Bimg, 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	–
J9039	Injection Blinatumomab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	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.	#N/A	#N/A	–	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.	#N/A	#N/A	–	10/10/2021
J9057	Inj. Copanlisib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	Moved to PA list	–
J9118	Inj. Calaspargase Pegol-Mknl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	–
J9119	Inj. Cemiplimab-Rwlc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	–
J9144	Daratumumab Hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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.	#N/A	#N/A	–	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.	#N/A	#N/A	–	10/10/2021
J9176	Injection Elotuzumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9177	Inj Enfort Vedo-Ejfv 0.25Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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.	#N/A	#N/A	Moved to PA list	–
J9204	Inj Mogamulizumab-Kpkc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9205	Inj Irinotecan Liposome 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9210	Inj. Emapalumat-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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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.	#N/A	#N/A	–	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.	#N/A	#N/A	Moved to PA list	–
J9264	Paclitaxel Protein Bound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9269	Inj. Tagraxofusp-Erzs 10 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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.	#N/A	#N/A	–	10/10/2021
J9281	Mitomycin Instillation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9285	Inj Olaratumab 10 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	5/15/2021	–
J9295	Injection Necitumumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	–	12/31/2021
J9299	Injection Nivolumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9301	Obinutuzumab Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9306	Injection Pertuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9308	Injection Ramucirumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9309	Inj Polatuzumab Vedotin 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	–
J9316	Injection, Pertuzumab, Trastuzumab, And Hyaluronidase-Zzxf, Per 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9317	Sacituzumab Govitecan-Hzly	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9325	Inj Talmogene 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	–
J9349	Injection, Tafasitamab-Cxix, 2Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	–
J9352	Injection Trabectedin 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	Moved to PA list	–
J9354	Inj Ado-Trastuzumab Emtr 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	–	10/10/2021
J9358	Inj Fam-Trastu Deru-Nxki 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9600	Porfimer Sodium Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.029	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus	–	–
J9999	Chemotherapy Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	MED203.002 RX501.063 RX501.087 RX501.085 RX501.057	–	–	–
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	Std 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	Std 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.	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.	DME101.010	Wheelchairs and Accessories	–	–
K0053	Elevate Footrest Articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0065	Spoke Protectors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0108	W/C Component-Accessory Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	–	–
K0455	Pump Uninterrupted Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	–	–
K0800	Pov Group 1 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0801	Pov Group 1 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0802	Pov Group 1 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0806	Pov Group 2 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0807	Pov Group 2 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	–	–
K0808	Pov Group 2 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 contract/clinical review.	DME101.010	Wheelchairs and Accessories	–	–
K0813	Pwc Gp 1 Std Port Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	–	–

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K1019	Monthly Supp Use With K1018	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	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	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
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	–
K1024	Non pneum comp control cal	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	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	–
K1025	Non pneum compress full arm	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	10/1/2021	12/31/2021
K1025	Non pneum compress full arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2022	–
K1027	Oral dev without fix mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	10/1/2021	–
K1030	Ext Recharge Bat Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.068	Cardiac Contractility Modulation (CCM) Device	2022-04-01	–
K1031	Non Pneu Comp Control W/O Ca	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	–
K1032	Non Pneum Seq Comp Full Leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	–
K1033	Non Pneum Seq Comp Half Leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	–
L0999	Add To Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L1499	Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
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 Contrl 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	KaI Sng/DbI Swg/Stn Mcpr Cus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
L2999	Lower Extremity Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L3040	Ft Arch Suprt Premold Longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
L3050	Foot Arch Supp Premold Metat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
L3060	Foot Arch Supp Longitud/Meta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
L3649	Orthopedic Shoe Modifica Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L3999	Upper Limb Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L5857	Elec Knee-Shin Swing Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	–	–
L5973	Ank-Foot Sys Dors-Plant Flex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	–	–
L5981	Flex-Walk Sys Low Ext Prosth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	–	6/30/2022
L5999	Lowr Extremity Prothes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L6026	Part Hand Myo Exclu Term Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	–	–
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 Myoelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	Microprocessor Control Uplimb	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 Disarticl Switch Ctrl	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	–	–
L6925	Wrist 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	–	–
L6930	Below 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 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 Lower-Limb Prosthesis	–	–
L6955	Above 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	–	–
L6960	Shldr Disartic Switch Contro	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	–	–
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 Lower-Limb Prosthesis	–	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	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7009	Adult Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7040	Prehensile Actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7045	Pediatric Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7170	Electronic Elbow Hosmer Swit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7180	Electronic Elbow Sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	–	–
L7181	Electronic Elbo Simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Lower-Limb Prosthesis	–	–

L7190	Elbow Adolescent Myoelectron	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	–	–
L7191	Elbow Child 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	–	–
L7259	Electronic Wrist Rotator Any	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
L7364	Twelve Volt Battery Utah/Equ	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	–	–
L7366	Battery Chgrg 12 Volt Utah/E	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	–	–
L7499	Upper Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L8039	Breast Prosthesis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L8048	Unspec Maxillofacial Prosth	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L8499	Unlisted Misc Prosthetic Ser	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L8604	Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	–	–
L8605	Inj Bulking Agent Anal Canal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	–	–
L8606	Synthetic Implt Urinary 1MI	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 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 CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	–	–
L8612	Aqueous Shunt Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	–	–
L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	–	–
L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may 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-Earlvl	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 predetermination to avoid post-service review.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	–	6/30/2022
L8699	Prosthetic Implant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
L8701	Ewh S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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.	–	–	–	–
P2031	Hair Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	–	–
P9020	Plaelet Rich Plasma Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	–	–
P9099	Blood Component/Product Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
Q0239	Bamlanivimab-Xxxx	Unlisted: Procedure/service not specifically defined or classified. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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 contract/clinical review.	–	–	–	–
Q0509	Mis Sup/Ac Imp Vad Nopay Med	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
Q0510	Dispens Fee Immunosuppressive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
Q0511	Sup Fee Antiem Antica Immuno	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
Q0512	Px Sup Fee Anti-Can Sub Pres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
Q2026	Radlesse Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	–	–
Q2028	Inj Sculptra 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Cioleucel 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.	#N/A	#N/A	–	10/10/2021
Q2050	Doxorubicin Inj 10Mg	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	–	–	–	–
Q2052	Ivig Demo Services/Supplies	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
Q2053	Brexucabtagene Autoleucel. Up To 200 Million Autologous Anti-CD19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	4/1/2021	–
Q2054	Lisocabtagene mara 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	–
Q2055	Idecabtagene Vicleucel Car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	1/1/2022	–

Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
Q4051	Splint Supplies Misc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	—	—	—	—
Q4082	Drug/Bio Noc Part B Drug Cap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified.	—	—	—	—
Q4100	Skin Substitute Nos	MP Criteria: Procedure/service reviewed against Medical 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 predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	—	—
Q4102	Oasis Wound Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	—	—
Q4103	Oasis Burn Matrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4104	Integra Bmwd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	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 predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	—	—
Q4108	Integra Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4112	Cymetra Injectable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4113	Graftjacket Xpress	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4114	Integra Flowable Wound Matri	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	—	—
Q4115	Alloskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	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	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	10/15/2021	—
Q4122	Dermacell Awm Porous 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	—	3/31/2021
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
Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4125	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4126	Memoderm/Derma/Tranz/Integup	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4127	Talymed Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4128	Flexhd/Allopatchhd/Matrixhd	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	—	—
Q4130	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4132	Grafix core grafixpl core	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	—
Q4133	Grafix stravix prime pl sqcm	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	—
Q4134	Hmatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4135	Mediskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	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 Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	—	—
Q4141	Alloskin Ac 1 Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4142	Xcm Biologic Tiss Matrix 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4143	Repriza 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—
Q4145	Epifix Inj 1Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	—	—
Q4146	Tensix 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	—



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Q4233	Surfact /Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4234	Xcellerate Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4235	Amniorepair Or Altiply Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4236	Carepatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	9/30/2021
Q4237	Cryo-Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4238	Derm-maxx, per sq cm	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
Q4238	Derm-maxx, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	7/1/2022	–
Q4239	Amnio-Maxx Or Lite Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4240	Corecyte Topical Only 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4241	Polycyte Topical Only 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4242	Amniocyte Plus Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4244	Procenta Per 200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4246	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4247	Amniotext Patch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4248	Dermactin Amn Mem Allo Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	–	–
Q4249	Amniplry 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	3/1/2021	–
Q4250	Amnioamp-Mp Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	–
Q4251	Vim per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	–
Q4252	Vendaje per square centimet	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4252	Vendaje per square centimet	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	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.	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4253	Zenith amniotic membrane psc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	–
Q4254	Novafix DI 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	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	EIU: Procedure/service not reimbursed 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	–
Q4258	Enverse Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	–
Q5009	Hospice Care Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
Q5103	Injection Inflectra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, 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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	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. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
Q5119	Inj. Ruxience 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
Q5124	Inj. Byovviz 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	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies	–	–
S0197	Prenatal Vitamins 30 Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S0310	Hospitalist Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S0320	Rn Telephone Calls To Dmp	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S0590	Misc Integral Lens Serv	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
S0622	Phys Exam For College	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–

S0800	Laser In Situ Keratomileusis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.001	Refractive and Therapeutic Keratoplasty	–	–
S0810	Photorefractive Keratectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S1001	Deluxe Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
S1002	Custom Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
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 Arthroscpy Harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	2022-05-01	–
S2117	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	–	–
S2118	Total Hip Resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, 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	–	–
S2140	Cord Blood Harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–
S2142	Cord Blood-Derived Stem-Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–
S2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.042 SUR703.035 SUR703.032 SUR703.031 SUR703.030 SUR703.046 SUR703.044 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	–	–
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	–	–
S2230	Implant Semi-imp Hear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	–	–
S2235	Implant Auditory Brain Imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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.	–	–	–	–
S2900	Surgical Techniques Requiring Use Of Robotic Surgical System (List Separately in Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.014	Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery	–	–
S3600	Stat Lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S3601	Stat Lab Home/Nf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S3650	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	–	–
S3652	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	–	–

S3900	Surface Emg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
S4015	Complete Ivf Nos Case Rate	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S4023	Incompl Donor Egg Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
S4025	Donor Serv Ivf Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
S4026	Procure Donor Sperm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
S4027	Store Prev Froz Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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-service review.	-	-	-	-
S5035	Hit Routine Device Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5036	Hit Device Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5100	Adult Daycare Services 15Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5101	Adult Day Care Per Half Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5102	Adult Day Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5105	Centerbased Day Care Perdiem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5108	Homecare Train Pt 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5109	Homecare Train Pt Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5110	Family Homecare Training 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5111	Family Homecare Train/Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5115	Nonfamily Homecare Train/15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5116	Nonfamily Hc Train/Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5120	Chore Services Per 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5121	Chore Services Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5125	Attendant Care Service /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5126	Attendant Care Service /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5130	Homemaker Service Nos Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5131	Homemaker Service Nos /Diem	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5135	Adult Companioncare Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5136	Adult Companioncare Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5140	Adult Foster Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5141	Adult Foster Care Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5145	Child Fostercare Th Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5146	Ther Fostercare Child /Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5150	Unskilled Respite Care /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5151	Unskilled Respitecare /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5160	Emer Response Sys Instal&Tst	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5161	Emer Rspns Sys Serv Permonth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5162	Emer Rspns System Purchase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5165	Home Modifications Per Serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5170	Homedelivered Prepared Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5175	Laundry Serv Ext Prof /Order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5181	Hh Respiratory Thrpy Nos/Day	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S5185	Med Reminder Serv Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5497	Hit Cath Care Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
S8130	Interferential Current Stimulator 2 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	-	-
S8131	Interferential Current Stimulator 4 Channel	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	-	-
S8189	Trach Supply Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S8270	Enuresis Alarm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S8301	Infect Control Supplies Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S8460	Camisole Post-Mast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S8930	Auricular Electrostimulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	-	-
S8940	Hippotherapy Per Session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.022	Hippotherapy	-	-
S8948	Low-Level Laser Trmt 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR702.005 MED201.045 MED205.022	Acne Management Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence Low-Level and High-Power Laser Therapy Treatment of Tinnitus	-	-



S8990	Pt Or Manip For Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9001	Home Uterine Monitor With Or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.017	Home Uterine Activity Monitoring	–	–
S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.014	Sensory Stimulation for Coma Patients	–	–
S9090	Vertebral Axial Decompressio	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.021	Non-Surgical Spinal Decompression Traction Devices	–	–
S9117	Back School Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.024	Back School	–	–
S9125	Respite Care In The Home P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9335	Ht Hemodialysis Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	–	–
S9379	Hit Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
S9381	Hit High Risk/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9436	Lamaze Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9437	Childbirth Refresher Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9439	Vbac Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9442	Birthing Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9444	Parenting Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9445	Pt Education Noc Individ	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	–	–	–	–
S9446	Pt Education Noc Group	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9447	Infant Safety Class	Unlisted: Procedure/service not specifically defined or classified	–	–	–	–
S9449	Weight Mgmt Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9451	Exercise Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–
S9454	Stress Mgmt Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	–	–	–	–