

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

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

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

Code	Code Description	Code Group & Description	Medical Policy No.	Medical Policy Title	Effective Date	Ending Date
00104	Anesth Electroshock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.013	Electroconvulsive Therapy	-	_
00640	Anesth Spine Manipulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	-
00797	Anesth Surgery For Obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	-
11200	Removal Of Skin Tags <w 15<="" td=""><td>Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.</td><td>-</td><td>-</td><td>10/1/2021</td><td>-</td></w>	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	10/1/2021	-
11200	Removal Of Skin Tags <w 15<="" td=""><td>MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.</td><td>SUR716.001</td><td>Cosmetic and Reconstructive Procedures</td><td>_</td><td>9/30/2021</td></w>	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	9/30/2021
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 Skn Color 6.1-20.0Cm	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	_	-
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 Sieen Related Forathine 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 Greathing 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 Berathing Disorder's 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	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures Reconstructive Preast Surgery	-	-
11980	Implant Hormone Pellet(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.063 SUR717.001 RX501.007 RX501.076	Compounded Drug Products Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies	-	-
15758	Free Fascial Flap Microvasc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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/<			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		THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review.	SUR717.001 THE801.030	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	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
13/62	Dermadrasion Other Than Face	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	=
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
15783	Dermabrasion Suprfl Any Site	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.030 THE801.028	Nonpharmacologic Treatment of Rosacea Acne Management		
15786	Abrasion Lesion Single	predetermination to avoid post-service review.	SUR716.001 SUR717.001	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	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review.	SUR717.001 THE801.028	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Acne Management		
15788	Chemical Peel Face Epiderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.018 SUR717.001	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
		predetermination to avoid post-service review.	THE801.030	Nonpharmacologic Treatment of Rosacea		
15789	Chemical Peel Face Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Acne Management Chemical Peels		
		predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	
15792		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.018	Acne Management Chemical Peels		
13/92	Chemical Peel Nonfacial	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	=
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.018	Acne Management Chemical Peels		
15793	Chemical Peel Nonfacial	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15820	Revision Of Lower Eyelid		THE801.030 SUR716.004	Nonpharmacologic Treatment of Rosacea Blepharoplasty, Blepharoptosis and Brow Repair		
15821	Revision Of Lower Evelid		SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair		
15822	***************************************	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair	-	
	Revision Of Upper Eyelid	predetermination to avoid post-service review.	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair	-	
15823	Revision Of Upper Eyelid	predetermination to avoid post-service review.	SUR717.001 SUR716.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures	-	_
15824	Removal Of Forehead Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15825	Removal Of Neck Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR712.031 SUR716.001	Surgical Deactivation of Headache Trigger Sites Cosmetic and Reconstructive Procedures	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001 SUR716.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures		
15826	Removal Of Brow Wrinkles	Prior Authorization per contract agreement.	SUR717.001 SUR712.031	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	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
13030	LAC SKIII ADU	predetermination to avoid post-service review.	SUR701.024	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
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	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15833	Excise Excessive Skin Leg	predetermination to avoid post-service review.	SUR717.001 SUR701.024	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	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
		predetermination to avoid post-service review.	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15835	Excise Excessive Skin Buttck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR701.024	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	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15837	Excise Excess Skin Arm/Hand	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	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15838	Excise Excess Skin Fat Pad	predetermination to avoid post-service review.	SUR717.001 SUR701.024	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	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
13833	Excise Excess Skill & 1133de	predetermination to avoid post-service review.	SUR701.024 SUR716.017	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 Lipectomy Head&Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
<u> </u>		predetermination to avoid post-service review.	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures	_	
15877	Suction Lipectomy Trunk	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	-	_
15070	Contraction 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria Submit for	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15878	Suction Lipectomy Upr Extrem	predetermination to avoid post-service review.	SUR717.001 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	
15879	Suction Lipectomy Lwr Extrem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
15999	Removal Of Pressure Sore	Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR701.024	Surgery for Lipedema and Lymphedema		
13333	Nemovar of Pressure Sore	contract/clinical review.	- THE801.028	- Acne Management	-	-
17106	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.008 THE801.030	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	THE801.028 SUR704.008	Acne Management		
	COLON OF JAME LESIURS	predetermination to avoid post-service review.	THE801.030	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	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations	-	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	THE801.030	Nonpharmacologic Treatment of Rosacea		
17340	Cryotherapy Of Skin	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE801.028	Acne Management	-	-
17360	Skin Peel Therapy	MB Critoria: Procedure/convice reviewed against Medical Bolicy Critoria, Submit for	THE801.028	Acne Management	-	-
17380	Hair Removal By Electrolysis		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.	-	angeriori anger; recommend the Mood	-	_
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	_
19300	Removal Of Breast Tissue	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.017	Surgical Treatment of Gynecomastia	_	_
19303	Mast Simple Complete		SUR717.001 SUR716.015	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
10310	Suspension Of Secret	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001	Risk-Reducing (Prophylactic) Mastectomy Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
19316	Suspension Of Breast	Prior Authorization per contract agreement.	SUR716.010 SUR716.011	Mastopexy Reconstructive Breast Surgery	-	-

19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
19510	Breast Reduction	Prior Authorization per contract agreement.	SUR716.011 SUR716.012	Reconstructive Breast Surgery Reduction Mammaplasty	-	-
19325	Breast Augmentation W/Implt		SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
19328	Rmvl Intact Breast Implant		SUR716.011 SUR716.009	Reconstructive Breast Surgery Breast Implant, Removal and/or Insertion		
19330	Rmvl Ruptured Breast Implant	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011 SUR716.009	Reconstructive Breast Surgery Breast Implant, Removal and/or Insertion		
	min raptarea oreast impaire	predetermination to avoid post-service review.	SUR716.011 SUR716.009	Reconstructive Breast Surgery Breast Implant, Removal and/or Insertion		
19340	Insj Breast Implt Sm D Mast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive Breast Surgery	-	-
40242	to d'Andread Bent Levels Con B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009	Breast Implant, Removal and/or Insertion		
19342	Insj/Rplcmt Brst Implt Sep D	predetermination to avoid post-service review.	SUR717.001 SUR716.011	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	SUR716.011	Reconstructive Breast Surgery	_	
19370	Revj Peri-Implt Capsule Brst	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009	Breast Implant, Removal and/or Insertion		
19371	Peri-Implt Capsic Brst Compl	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	_	
		MP Criteria: Procedure/service reviewed against Medical Criteria.	SUR716.021 SUR701.037	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery		
19499	Breast Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.031	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery		
20527	Inj Dupuytren Cord W/Enzyme	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	-	_
20560	Ndl Insj W/O Njx 1 Or 2 Musc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
20561	Ndl Insj W/O Njx 3+ Musc	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	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
20985	Cptr-Asst Dir Ms Px	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		Manipulation Under Anesthesia	_	_
21089	Prepare Face/Oral Prosthesis	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
	,,	contract/clinical review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
21120	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery		
		predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010 SUR716.001	Temporomandibular Joint (TMJ) Disorders (TMJD) Cosmetic and Reconstructive Procedures		
21121	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery	_	
		predetermination to avoid post-service review.	SUR706.009 SUR705.010	Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)		
			SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures		
21122	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery	_	_
			SUR706.009 SUR705.010	Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)		
			SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21123	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.030	Orthognathic Surgery	-	-
			SUR706.009 SUR705.010	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	CLID717 001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery		
		Prior Authorization per contract agreement.	SUR706.009	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.	SUR705.010	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.	SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
21150	Lefort Ii Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery	_	_
21151	Lefort Ii W/Bone Grafts	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
		Prior Authorization per contract agreement. MAD Criteria: Procedure (sociale regions descine) Madical Balia: Criteria may require			-	-
21154	Lefort Iii W/O Lefort I	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	3UK/U3.U3U	Orthognathic Surgery	-	-
21155	Lefort Iii W/ Lefort I	Prior Authorization per contract agreement.		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.	301703.030	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.		Orthognathic Surgery	-	_
21188	Reconstruction Of Midface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery	_	_
21206	Reconstruct Upper Jaw Bone	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
21208	Augmentation Of Facial Bones	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Orthognathic Surgery		
		Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
21209	Reduction Of Facial Bones	Prior Authorization per contract agreement. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		Orthognathic Surgery Orthognathic Surgery	-	-
21248	Reconstruction Of Jaw	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	_	_	_	_
21685	Hyoid Myotomy & Suspension	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management		
21899		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
	Neck/Chest Surgery Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
22505	Manipulation Of Spine	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	THE803.016	Manipulation Under Anesthesia	-	-
22586	Prescri Fuse W/ Instr L5-S1	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR712.038	Axial Lumbosacral Interbody Fusion	_	_
22899	Spine Surgery Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
22999	Abdomen Surgery Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Criteria.	-	-	-	-
23929	Shoulder Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.032	Shoulder Resurfacing	-	-
I .		contract/clinical review.				

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	THE803.016	Manipulation Under Anesthesia		
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
25999	Forearm Or Wrist Surgery	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
26340	Manipulate Finger W/Anesth	predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	_
26341	Manipulat Palm Cord Post Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	THE803.016	Manipulation Under Anesthesia		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			_	_
27279	Arthrodesis Sacroiliac Joint	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	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR702.017 SUR705.019	Facet Joint and Sacroiliac Joint Denervation Hip Resurfacing (HR)		
27299	Pelvis/Hip Joint Surgery	Prior Authorization per contract agreement until 04/01/2022.	SUR705.036	Surgery for Groin Pain in Athletes	-	-
27412	Autochondrocyte Implant Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.029 SUR705.035	Surgical Treatment of Femoroacetabular Impingement (FAI) Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	Moved to PA list	12/31/2021
		Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	301703.033	rationgous cholatory companion (ref) to recurrence at things castors	MOVED TO TAXABLE	12/31/2021
27599	Leg Surgery Procedure	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	THE803.016	Manipulation Under Anesthesia	_	_
27899	Leg/Ankle Surgery Procedure	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	_	-	_	-
28446	Osteochondral Talus Autogrft	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 CPCP08, which is one of our Clinical Payment and Coding	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	_	_
		Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
28899	Foot/Toes Surgery Procedure	contract/clinical review.	-	-	-	-
29440	Addition Of Walker To Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-	-
29799	Casting/Strapping Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
29862	Hip Arthr0 W/Debridement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	6/30/2022
29866		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions		
29000	Autgrft Impint Knee W/Scope	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	_	_
29868	Meniscal Trnspl Knee W/Scpe	predetermination to avoid post-service review. PA maybe required until	SUR705.034	Meniscal Allografts and Other Meniscal Implants	1/1/2022	6/30/2022
		04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
29914	Hip Arthro W/Femoroplasty	predetermination to avoid post-service review. PA maybe required until 04/01/2022.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
29915	Hip Arthro Acetabuloplasty	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 Asthro W/Lohrol Donois	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.029	Curainal Treatment of Ferreseasciabular Impirement (FAI)	1/1/2022	
23310	Hip Arthro W/Labral Repair	predetermination to avoid post-service review. PA maybe required until 04/01/2022.		Surgical Treatment of Femoroacetabular Impingement (FAI)	1/1/2022	-
29999	Arthroscopy Of Joint	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR705.029 SUR705.041	Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability		
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.024	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
30400	Reconstruction Of Nose	Prior Authorization per contract agreement.	SUR706.001	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		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
30430	Revision Of Nose	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR706.001 SUR717.001	Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
30435	Revision Of Nose	Prior Authorization per contract agreement.	SUR706.001	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	SUR706.017	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	2/15/2021	5/14/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
30468	Rpr Nsl Vlv Collapse W/Implt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.017	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	5/15/2021	-
30999	Nasal Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR706.001	_	_	_
31299	Sinus Surgery Procedure		SUR706.019			
		contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR706.001		_	_
31599	Larynx Surgery Procedure	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	SUR706.015	Bronchial Valves	_	6/30/2022
31651	Bronchial Valve Addl Insert	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.015	Bronchial Valves		6/30/2022
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	-, 50, 2022
31899	Airways Surgical Procedure	contract/clinical review.	-	-	-	-
32994	Ablate Pulm Tumor Perq Crybl	predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	-
32998	Ablate Pulm Tumor Perq Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	_	_
32999	Chest Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	_	_
33211	Insert Card Electrodes Dual	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
33213	Insert Pulse Gen Dual Leads	predetermination to avoid post-service review.	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	-	6/30/2022
	L Ventric Pacing Lead Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	_	6/30/2022
33225		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.030	Leadless Cardiac Pacemaker	_	_
	Tcat Insj/Rpl Perm Ldls Pm					
33274		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707 030	Leadless Cardiac Pacemaker		
33274 33275	Tcat Rmvl Perm Ldls Pm W/Img	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MR Criteria: Procedure/service review.	SUR707.030	Leadless Cardiac Pacemaker Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and	-	-
33274 33275		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.030 MED202.003	Leadless Cardiac Pacemaker Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
	Tcat Rmvl Perm Ldls Pm W/Img	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and	<u>-</u> -	- - 3/31/2021
33274 33275 33285	Tcat Rmvl Perm Ldls Pm W/Img Insj Subq Car Rhythm Mntr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Dredetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	- - -	- - 3/31/2021 6/30/2022

33999	Cardiac Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR707.026 SUR701.009	Cardiac Restoration and Remodeling Procedures Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation	_	_
25200		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR703.027	Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia		
36299	Vessel Injection Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	<u>-</u>	_	-
36465	Njx Noncmpnd Sclrsnt 1 Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	-	_
36466	Njx Noncmpnd Scirsnt Mlt Vn	predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	_
36468	Njx Sclrsnt Spider Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	_
36470	Njx Scirsnt 1 Incmptnt Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	_
36471	Njx Scirsnt Mit Incmptnt 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	SUR707.016	Varicose Vein Management		
30473	Endovenous Wichilchem 13t Vein	Policy (CPCP).	301707.010	valicose vein Management	_	-
36474	Endovenous Mchnchem Add-On		SUR707.016	Varicose Vein Management	_	_
36475	Endovenous Rf 1St Vein	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
	Endovenous Rf Vein Add-On	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
36476		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	
36478	Endovenous Laser 1St Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	-	_
36479	Endovenous Laser Vein Addon	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	THE801.026	Extracorporeal Photopheresis (ECP)	_	6/30/2022
37215	Transcath Stent Cca W/Eps	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.028	Extracranial Carotid Angioplasty or Stenting		
37216	Transcath Stent Cca W/O Eps	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.028	Extracranial Carotid Angioplasty or Stenting	_	
37217	Stent Placemt Retro Carotid	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.028	Extracranial Carotid Angioplasty or Stending	_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
37218	Stent Placemt Ante Carotid	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.028	Extracranial Carotid Angioplasty or Stenting	_	_
37241	Vasc Embolize/Occlude Venous	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	Radioembolization for Primary and Metastatic Tumors of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	_	_
37244	Very Frederice (October Bland	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.022 SUR701.015	Transcatheter Arterial Chemoembolization (TACE) of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions		
	Vasc Embolize/Occlude Bleed	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
37500	Endoscopy Ligate Perf Veins	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR707.016	Varicose Vein Management	-	_
37501	Vascular Endoscopy Procedure	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	SUR707.016	Varicose Vein Management	_	_
37765	Stab Phleb Veins Xtr 10-20	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	
37766	Phleb Veins - Extrem 20+	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016		_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	_	
37780	Revision Of Leg Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	-	
37785	Ligate/Divide/Excise Vein	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR707.016	Varicose Vein Management	_	_
37799	Vascular Surgery Procedure	contract/clinical review.	-	-	-	-
38129	Laparoscope Proc Spleen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
38204	Bl Donor Search Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.043 SUR703.043 SUR703.043 SUR703.047 SUR703.047 SUR703.036 SUR703.039 SUR703.029 SUR703.029 SUR703.034 SUR703.034 SUR703.034 SUR703.035 SUR703.035 SUR703.040	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 Symdrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Symdrome (AIDS) Hematopoietic Cell Transplantation for Greats Cansers Hematopoietic Cell Transplantation for Greats (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Formatic Nervous System (AIDS) Hematopoietic Cell Transplantation for Semetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Melignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	-	-
			SUR703.044 SUR703.050 SUR703.045	Hematopoletic Cell Transplantation for Solid Tumors in Children Hematopoletic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoletic 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 SUR703.003 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Meliopath Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Mal-Hodgish Immphomas Hematopoietic Cell Transplantation for Non-Hodgish Imphomas Hematopoietic Cell Transplantation for Non-Hodgish Imphomas Hematopoietic Cell Transplantation for Non-Hodgish Imphomas Hematopoietic Cell Transplantation for Finars y Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Finars y Systemic Amyloidosis 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 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.045 SUR703.035 SUR703.045 SUR703.035 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.045 SUR703.046 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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Morthing System State (AID) Hematopoietic Cell Transplantation for Morthing Mattopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Morthing Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodglish Imymphomas Hematopoietic Cell Transplantation for Non-Hodglish Imymphomas Hematopoietic Cell Transplantation for Non-Hodglish Imymphomas Hematopoietic Cell Transplantation for Morthing Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Morthing Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Morthing Myeloproliferative Macoglobulinemia Hematopoietic Cell Transplantation for Morthing Mattiple Myeloproliferative Macoglobulinemia Hematopoietic Cell Transplantation for Morthing Mattiple Myeloproliferative Macoglobulinemia	
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 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.034 SUR703.041 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.046 SUR703.046 SUR703.046	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 Autoimmuno Biseases 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 Epithelia Ovarian Cancer Hematopoietic Cell Transplantation for Hodgieln Uprahoma (HL) Hematopoietic Cell Transplantation for Hodgieln Uprahoma (HL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Palmar Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Palmar Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children	
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 SUR703.002 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.041 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 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 Autoimmuno Biseases Hematopoietic Cell Transplantation for Autoimmuno Biseases Hematopoietic Cell Transplantation for Centrol Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgieln Upryphomal (HL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solf Tumors in Children	

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 SUR703.002 SUR703.043 SUR703.043 SUR703.036 SUR703.039 SUR703.029 SUR703.039 SUR703.030 SUR703.035 SUR703.035 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.035 SUR703.035 SUR703.035 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 Reast Canacome (AIDS) Hematopoietic Cell Transplantation for Breast Canacome (AIDS) 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 Formic Myeloid Leukemia Hematopoietic Cell Transplantation for Splatical Ovarian Canacor Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Palma Cell Diseases, MDS and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Palma Cell Diseasasia, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Palma Cell Diseasasia, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Waldersplantation Macroglobulinemia Hematopoietic Cell Transplantation for Malignant for Macroglobulinemia Hematopoietic Cell Transplantation for Malignant for Macroglobulinemia Hematopoietic Cell Transplantation for Malignanton Macroglobulinemia	
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 SUR703.002 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.055 SUR703.055 SUR703.055 SUR703.040 SUR703.055 SUR703.055 SUR703.040 SUR703.040	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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Action muno Biseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Stiphelail Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Molegian Hymphoma (HL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Molegian Hymphomas Hematopoietic Cell Transplantation for Molegian Hymphomas Hematopoietic Cell Transplantation for Molegian Hymphomas Hematopoietic Cell Transplantation for Finary Systemic Amyloidosis Hematopoietic Cell Transplantation for Molegian Matopoietic Matopoietic Cell Transplantatio	
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 SUR703.003 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.041 SUR703.045 SUR703.030 SUR703.040 SUR703.030 SUR703.040 SUR703.040 SUR703.040 SUR703.050 SUR703.050 SUR703.050 SUR703.050 SUR703.050 SUR703.050 SUR703.050 SUR703.055	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 Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for More Michel Cell Enderson (Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for More Michel Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for More Michel Imphomas Hematopoietic Cell Transplantation for Non-Hodgish Imphomas Hematopoietic Cell Transplantation for Non-Hodgish Imphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Foliam for in Children Hematopoietic Cell Transplantation for Solid Tumors in Children	
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 SUR703.036 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.030 SUR703.034 SUR703.035 SUR703.040 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.036 SUR703.036 SUR703.036 SUR703.046 SUR703.046 SUR703.046 SUR703.046 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 Acutine Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoinemuno Biseases Hematopoietic Cell Transplantation for Sensat Cancer Hematopoietic Cell Transplantation for Centrol Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelal Ovarian Cancer Hematopoietic Cell Transplantation for Epithelal Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HJL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HJL) Hematopoietic Cell Transplantation for Misclainenous Solid Tumors in Adults Hematopoietic Cell Transplantation for Misclainenous Solid Tumors in Adults 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 Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children	-

38213	Platelet Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.030 SUR703.031 SUR703.045 SUR703.046 SUR703.046 SUR703.046 SUR703.046	Hematopoietic Cell Transplantation (FC) 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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Breast Canace Hematopoietic Cell Transplantation for Greast Canace Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (ELL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Spithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgish Lymphoma (HJL) Hematopoietic Cell Transplantation for Hodgish Lymphoma (HJL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dycarsais, Including Multiple Myeloma (MMI) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dycarsais, Including Multiple Myeloma (MMI) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Cell Transplantation for Soll Tumors in Children Hematopoietic Cell Transplantation for Plasma Cell Cell Transplantation for Soll Tumors in Children Hematopoietic Cell Transplantation for Plasma Cell Cell Transplantation for Soll Tumors in Children Hematopoietic Cell Transplantation for Plasma Cell Cell Transplantation for Soll Tumors in Children Hematopoietic Cell Transplantation for Soll Tumors in Children	
38214	Volume Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.045 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.039 SUR703.041 SUR703.042 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.036	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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma (SILL) Hematopoietic Cell Transplantation for Central Disclosed Leukemia (CLL) and Small Lymphocytic Lymphoma (SILL) Hematopoietic Cell Transplantation for Genetic Disclosease and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Disclosease and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Tor Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Miscellaneous Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Tor Primary Systemic Amyloidosis	
38215	Harvest Stem Cell Concentrte	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.034 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.035 SUR703.045 SUR703.035 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 Immunodefriciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodefriciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Lymphoma (Hall) Hematopoietic Cell Transplantation for Hodgis In Urphymoma (Hall) Hematopoietic Cell Transplantation for Modgis In Urphymoma (Hall) Hematopoietic Cell Transplantation for Modgishi Lymphomas Hematopoietic Cell Transplantation for Non-Hodgishi Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (HM) and POEMS Syndrome Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	
38230	Bone Marrow Harvest Allogen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.035 SUR703.040 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.030 SUR703.030 SUR703.030 SUR703.046 SUR703.040	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 Immunodefricency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodefricency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Lymphoma (HL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (HM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	
38232	Bone Marrow Harvest Autolog	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.045 SUR703.045 SUR703.045 SUR703.055	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Receipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Melloghant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Myeloodysbastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Neoplasmistic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dycrassias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dycrassias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Foslid Tumors in Children Hematopoietic Cell Transplantation for Foslid Tumors in Children Hematopoietic Cell Transplantation for Foslid Tumors in Children	

38240	Transplt Allo Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.037 SUR703.047 SUR703.047 SUR703.047 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.031 SUR703.041 SUR703.043 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 Autonumo Diseases Hematopoietic Cell Transplantation for Movernome Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (LLL) and Small Lymphocytic Lymphoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (LLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Fibridia Davarian Cancer Hematopoietic Cell Transplantation for Fibridia Davarian Cancer Hematopoietic Cell Transplantation for Hodgich Inymphoma (HL) Hematopoietic Cell Transplantation for Movelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Planse Leid Dycrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Planse Leid Dycrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Planse Leid Dycrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children	-	-
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 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.050 SUR703.050 SUR703.050 SUR703.050 SUR703.044	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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Servat Cancer Hematopoietic Cell Transplantation for Servat 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 Myelodic Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Misicand Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Misicand Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Misicallaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Monthologic Myelomyphoma Hematopoietic Cell Transplantation for Misicand Myelomyphoma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Misicallaneous Colla Tumors in Children Hematopoietic Cell Transplantation for Genetic Cell Transplantation for Solid Tumors in Children	-	-
38242	Transplt Alio Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.041 SUR703.034 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.055	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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Mostific North Acquired Anemias Hematopoietic Cell Transplantation for Mostific Impriboma (HLI) Hematopoietic Cell Transplantation for Mostific Impriboma (HLI) Hematopoietic Cell Transplantation for Mostific Impriboma (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for North-Odds Intrymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children	-	-
38243	Transplj Hematopoletic Boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.045 SUR703.039 SUR703.039 SUR703.041 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.040 SUR703.035	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 Autoimmune Diseases 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 Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for More More Acquired Anemias Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for More More More Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for More More Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pilasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Maldenstrom 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	SUR701.021	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver		
		Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR706.009	Sleep Related Breathing Disorders: Surgical Management		
41599	Tongue And Mouth Surgery	onitisted. Procedure/service into specimically defined of classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
41820	Excision Gum Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
41821	Excision Of Gum Flap	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	_	-	_	_
41872	Repair Gum	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
41874	Repair Tooth Socket	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		_
41899		review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	-	_
	Dental Surgery Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	_	-	-	-
42145	Repair Palate Pharynx/Uvula	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	MED201.038	Confocal Laser Endomicroscopy (CLE)		
	, , , , , , , , , , , , , , , , , , , ,	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				_
43210	Egd Esophagogastrc Fndopisty	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	Bariatric Surgery Botulinum Toxin	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)		
43252	Egd Optical Endomicroscopy	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/Thrml Txmnt Gerd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	_	6/30/2022
43284	Laps Esophgl Sphnctr Agmntj	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.			_	_
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	Fronhagus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Esophagus Surgery Procedure	contract/clinical review. May require PA per contract agreement until 03/31/2022.		-	-	-
43633	Removal Of Stomach Partial	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	SUR716.003	Bariatric Surgery	_	_
43771	Lap Revise Gastr Adj Device	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
43772	Lap Rmvl Gastr Adj Device	MR Criteria: Procedure (sequice review against Medical Policy Criteria, Submit for	SUR716.003	Bariatric Surgery	_	
43773		predetermination to avoid post-service review. MR Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for			_	
	Lap Replace Gastr Adj Device	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	-	
43774	Lap Rmvl Gastr Adj All Parts	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	SUR716.003	Bariatric Surgery	_	
43847	Gastric Bypass Incl Small I	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	
43848	Revision Gastroplasty	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
43886	Revise Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003			-
	*	predetermination to avoid post-service review.		Bariatric Surgery	-	
43887	Remove Gastric Port Open	predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	
43888	Change Gastric Port Open	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 Critoria: Procedure (caprice reviewed against Medical Policy Critoria, Submit for	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	_		-	_
44979	Laparoscope Proc App	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
45399	Unlisted Procedure Colon	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
45499	Laparoscope Proc Rectum	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
45999	Rectum Surgery Procedure	contract/clinical review.	-	-	-	-
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	SUR709.032	Plugs for Fistula Repair	-	_
46999	Anus Surgery Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		- State of the state of Park and Advantage of the state o	-	-
47370	Laparo Ablate Liver Tumor Rf	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	_
47379	Laparoscope Procedure Liver	contract/clinical review. MB Criteria: Bracedure/caprice reviewed against Medical Policy Criteria: Submit for	-	-	-	-
47380	Open Ablate Liver Tumor Rf	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	_	-	-	_
47000		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
47999	Bile Tract Surgery Procedure	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	SUR703.007 SUR703.008	Kidney Transplant		
30300	Transplantation of Ridney	predetermination to avoid post-service review.	SUR703.013	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	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	_
50949	Laparoscope Proc Ureter	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
51715	Endoscopic Injection/Implant	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	_	-
51999	Laparoscope Proc Bla	contract/clinical review.	_	-	-	-
52327	Cystoscopy Inject Material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.022	Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	_	_
52441	Cystourethro W/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift	_	_
52442	Cystourethro W/Addl Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.023	Prostatic Urethral Lift		
53855	Insert Prost Urethral Stent	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.025	Temporary Prostatic Stent		
33633	lisert Prost Oretinal Stellt	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	WED201.025	remporary Prostatic Stent	_	_
53860	Transurethral Rf Treatment	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	-	-
53899	Healam Cueron Depondues	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Urology Surgery Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	_	-
54125	Removal Of Penis	predetermination to avoid post-service review.	SUR717.001 RX501.073	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Clostridial Collagenase for Fibroproliferative Disorders	-	
54200	Treatment Of Penis Lesion	predetermination to avoid post-service review.	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	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	_	_
54400	Insert Semi-Rigid Prosthesis		MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	
54401	Insert Self-Contd Prosthesis	predetermination to avoid post-service review.	MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
54405	Insert Multi-Comp Penis Pros	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	
54660	Revision Of Testis	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	_	_	_	_
55706	Prostate Saturation Sampling	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.015	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with		6/30/2022
55880		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Biopsy		0,30,2022
55880	Abltj Mal Prst8 Tiss Hifu	predetermination to avoid post-service review.	SUR717.014 SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer 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.	SUR701.031	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	_	_
55970	Contraction May 5	MP Critoria: Procedure/consider reviewed against Medical Policy Critoria. Submit for	SUR710.019	Nerve Graft With Radical Prostatectomy		
	Sex Transformation M To F	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
55980	Sex Transformation F To M	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
56805	Repair Clitoris	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.			-	_
56810	Repair Of Perineum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions. Assessment and Treatment	-	_
56810 57291		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 MED201.030 SUR717.001		-	-
57291	Repair Of Perineum Construction Of Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
57291 57292	Repair Of Perineum Construction Of Vagina Construct Vagina With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	-
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64561	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.		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 Mpltj Hpglsl Nstm Ary Pg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	2022-05-01	_
64628	Trml Dstrj los Bvn 1St 2 L/S	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-05-01	2022-07-31
1 1 1		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
64628	Trml Dstrj los Bvn 1St 2 L/S	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-08-01	-
64629	Trml Dstrj Ios Bvn Ea Addl	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	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain	2022-05-01	2022-07-31
64629	Trml Dstrj Ios Bvn Ea Addl	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 RX501.019	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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	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	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	Impltj 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	SUR713.032	Viscocanalostomy and Canaloplasty	_	_
66175	Trnslum Dil Eye Canal W/Stnt	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.032	Viscocanalostomy and Canaloplasty	_	
66179		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
	Aqueous Shunt Eye W/O Graft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma		_
66180	Aqueous Shunt Eye W/Graft	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	_		_	_
67299	Eye Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	<u>-</u>	_	-
67399	Unlisted Px Extraocular Musc	contract/clinical review.	-	<u>- </u>	-	-
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	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67903	Repair Eyelid Defect	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair		
67904		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
	Repair Eyelid Defect	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	
67906	Repair Eyelid Defect	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				
69090	Pierce Earlobes	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
69300	Revise External Ear	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
69399	Outer Ear Surgery Procedure	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 Dilation 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 Dilation of the Eustachian Tube	1/15/2021	-
69714	Implant Temple Bone W/Stimul	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_
69715	Temple Bne Implnt W/Stimulat	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids		12/31/2021
69717	Temple Bone Implant Revision	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Implantable Bone-Conduction and Bone-Anchored Hearing Aids		
	· ·	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	30K/14.003		-	-
69718	Revise Temple Bone Implant	Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	12/31/2021
69799	Middle Ear Surgery Procedure	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	_	-	_	_
76496	Fluoroscopic Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
76497	Ct Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
76498	Mri Procedure	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	_			
77499	Radiation Therapy Management	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	-
77799	Radium/Radioisotope Therapy	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				
78399	Musculoskeletal Nuclear Exam	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		<u>-</u>		
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
78499	Cardiovascular Nuclear Exam	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
78599	Respiratory Nuclear Exam	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	_	_	_	_
79999	Nuclear Medicine Therapy	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
80299	Quantitative Assay Drug	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		<u>-</u>		_
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
81099	Urinalysis Test Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	-	-	-	-
81422	Fetal Chrmoml Microdeltj	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 Maaa	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
82523	Collagen Crosslinks	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.116	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover		
02323	conden crossinio	Policy (CPCP).	MED207.110	Total Carlotte Hankers to Suggious and Hangarite Cit Oscoporosis and Oscoses resoluted With Ingir Both Carlotte	-	-
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	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease		_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
83698	Assay Lipoprotein Pla2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
83701	Lipoprotein Bld Hr Fraction	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	MED 207 009	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease		
03704	Elpoprotein dia Quan Fai t	Policy (CPCP).	WIED207.000	Novel biolital xells in Nax Assessment and Wanagement of Caldiovascular Disease		-
83722	Lipoprtn Dir Meas Sd Ldl Chl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
83937	Assay Of Osteocalcin	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	_	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
83987	Exhaled Breath Condensate	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	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
84431	Thromboxane Urine	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.148	Measurement of Thromboxane Metabolites in Urine	_	_
84999	Clinical Chemistry Test	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
85999	Hematology Procedure	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-	-	-
86001	Allergen Specific Igg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED206.001	Allergy Management	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
86343	Leukocyte Histamine Release	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	MED207.147	Immune Cellular Function Assay to Monitor and Predict Immune Function	_	_
86353	Lymphocyte Transformation	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.088	Intracellular Micronutrient Analysis		
86486		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
	Skin Test Nos Antigen	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	-
86849	Immunology Procedure	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	-
86910	Blood Typing Paternity Test	review.	-	-	-	_
86911	Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
			SUR703.037	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and		
			SUR703.002 SUR703.043	Recipient Information)		
			SUR703.047	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.036 SUR703.038	Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.039 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) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
86950	Leukacyte Transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.034 SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	_	_
		predetermination to avoid post-service review.	SUR703.040 SUR703.042	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)		
			SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.032 SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas		
			SUR703.030 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 Hematopoietic Cell Transplantation for Solid Tumors in Children		
			SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors		
86999	Transfusion Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to		Con rangement of the restrict of Certifical Fullots		
87505	Nfct Agent Detection Gi	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	- Gastrointestinal Panels		-
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
87506	ladna-Dna/Rna Probe Tq 6-11	predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	-	_
87507	ladna-Dna/Rna Probe Tq 12-25	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	-	_
87797	Detect Agent Nos Dna Dir	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
87798	Detect Agent Nos Dna Amp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
87799	Detect Agent Nos Dna Quant	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
		Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
87899	Agent Nos Assay W/Optic	and the state of t	_			
87899 87999	Agent Nos Assay W/Optic Microbiology Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-			

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				
88012	Autopsy (Necropsy) Gross	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	_
88014	Autopsy (Necropsy) Gross	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	_	_	_	_
88027	Autopsy (Necropsy) Complete	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
88028	Autopsy (Necropsy) Complete	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
88029	Autopsy (Necropsy) Complete	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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-		-
88099	Necropsy (Autopsy) Procedure	review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
88199	Cytopathology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
88299	Cytogenetic Study	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		-		
00233	cytogenetic study	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-	_	-
88375	Optical Endomicroscpy Interp	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
88399	Surgical Pathology Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	_			_
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_			-
88749	In Vivo Lab Service	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
89240	Pathology Lab Procedure	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	MAD Critoria, Dependure from the society against Madical Delia, Critoria Culturi for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
89337	Cryopreservation Oocyte(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss		
89342	Storage/Year Embryo(S)	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
89343	Storage/Year Sperm/Semen	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	
89344	Storage/Year Reprod Tissue	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	RX504 003	Autism Spectrum Disorders (ASD) Immunoplobulin (le) Therapy (Including Intravenous (IVIG) and Subrutaneous (# [SCIG])	_	_
90283 90284	Human Ig Iv	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX504 003	Autism Spectrum Disorders (ASD) Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig (SCIG)) Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig (SCIG))	-	-
90284	Human Ig Sc	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	-	-
90284	Human Ig Sc Rsv Mab Im 50Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	- -
90284	Human Ig Sc	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/Clinical review.	RX504.003 RX504.003 RX504.009	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	-	-
90284	Human Ig Sc Rsv Mab Im 50Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	RX504.003 RX504.003 RX504.009	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	- - - - 7/1/2022	-
90284 90378 90399 90584	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	RX504.003 RX504.009 -	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	- - - - 7/1/2022	-
90284 90378 90399 90584 90689	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq Vacc Iiv4 No Prsrv 0.25Ml Im	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	RX504.003 RX504.009 -	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	- - - - 7/1/2022	-
90284 90378 90399 90584	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX504.003 RX504.009 -	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	- - - - 7/1/2022	-
90284 90378 90399 90584 90689	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq Vacc Iiv4 No Prsrv 0.25Ml Im	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/Clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/Clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX504.003 RX504.009 -	Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (Including Intravenous [IV/IG] and Subcutaneous Ig (SCIG])	- - - - - 7/1/2022	- - - - -
90284 90378 90399 90584 90689 90749	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq Vacc liv4 No Prsrv 0.25Ml Im Vaccine Toxold	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not ocvered by the Plan. Not subject to pre-service review. Unitsted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service most specifically defined or classified, may be subject to contract/clinical review.	RX504.003 RX504.009	Immunoglobulin (Ig) Therapy (including intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (including intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Respiratory Syncytial Virus (RSV) Immunoprophylaxis	- - - - 7/1/2022 - -	-
90284 90378 90399 90584 90689 90749 90867	Human Ig Sc Rsv Mab Im 50Mg Immune Globulin Dengue Vacc Quad 2 Dose Subq Vacc liv4 No Prsrv 0.25Ml Im Vaccine Toxoid Tcranial Magn Stim Tx Plan	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Procedure/service reviewed against Medical Policy Criteria.	RX504.003 RX504.009	Immunoglobulin (Ig) Therapy (including intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Immunoglobulin (Ig) Therapy (including intravenous [IV/IG] and Subcutaneous Ig (SCIG]) Respiratory Syncytial Virus (RSV) Immunoprophylaxis	- - - - - - - -	-
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91034	Gastroesophageal Reflux Test	MP Citteria: Procedure/service reviewed against Medical Policy Criteria. Submit for medical policy Criteria. Submit for MED201.005 Esophageal pH Monitoring redetermination to avoid post-service review.	-	-
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 MED207.161 Hydrogen or Methane Breath Testing		
	breath Hydrogen, Wethanie Test	Policy (CPCP).	-	-
91110	Gi Tract Capsule Endoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RAD601.042 predetermination to avoid post-service review. 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 RAD601.042 Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	-	_
		Policy (PCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service		
91112	Gi Wireless Capsule Measure	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.017 Gastrointestinal (GI) Motility Measurement Policy (CPCP).	-	-
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 MED201.017 Gastrointestinal (GI) Motility Measurement		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-
91133	Electrogastrography W/Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.017 Gastrointestinal (GI) Motility Measurement	-	-
91299	Gastroenterology Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_
92015	Determine Refractive State	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
92065	Orthoptic/Pleoptic Training	review. – – . Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-
	отпорис/ неорис таппід	review. – – – EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-
92132	Cmptr Ophth Dx Img Ant Segmt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OTH903.021 Optical Coherence Tomography of the Anterior Eye Segment Policy (CPCP).	-	-
92145	Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OTH903.031 Corneal Hysteresis		
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92340	Fit Spectacles Monofocal	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	_	_
92512	Need Seeding Studies	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		
92512	Nasal Function Studies	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED204.004 Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry Policy (CPCP).	-	-
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 EUD policy CPC09. Which is one of our Clinical Payment and Coding MED201.047 Vestibular Function Testing	5/15/2021	_
		Policy (CPCP).		
02540		MP Criteria: Procedure/service reviewed against Medical Policy Criteria Submit for		- / /
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
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92518 92519 92519 92519 92546 92548 92549 92640 92700 93050 93228 93229 93660 93792 93790 93791 93798 93799 93998 94014 94015 94452 94453	Vemp Test I&R Ocular Vemp Tst I&R Cervical&Ocular Sinusoidal Rotational Test Cdp-Sot 6 Cond W/I&R Cdp-Sot 6 Cond W/I&R Mct&Adt Aud Brainstem Impit Programg Ent Procedure/Service Art Pressure Waveform Analys Remote 30 Day Ecg Rev/Report Remote 30 Day Ecg Rev/Report Remote 30 Day Ecg Tech Supp Tilt Table Evaluation Bis Xtracell Fluid Analysis Temperature Gradient Studies Cardiac Rehab Cardiac Rehab/Monitor Cardiovascular Procedure Noninvas Vasc Dx Study Proc Patient Recorded Spirometry Patient Recorded Spirometry Review Patient Spirometry Hast W/Report Hast W/Report	MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for EUR (PAPE) and Circuits Procedum/service and terminates by the Plan. Nat subject to pre-service procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service reviewed against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for Pape (PCPC). MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable against Medical Policy Circuits, Submit for MC Circuits Procedum/service not reviewable agains	5/15/2021 2/15/2021 5/15/2021	-

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	MED206.001	Allergy Management		
		Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	PSY301.014	Autism Spectrum Disorders (ASD)		-
95199	Allergy Immunology Services	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 Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	_
95706	Eeg Wo Vid 2-12Hr Intmt Mntr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		,		
95707	Eeg W/O Vid 2-12Hr Cont Mntr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	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	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
95712	Veeg 2-12 Hr Intmt Mntr	predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	
95713	Veeg 2-12 Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95714	Veeg Ea 12-26 Hr Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	_
95715	Veeg Ea 12-26Hr Intmt Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	_
95716	Veeg Ea 12-26Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	
95718	Eeg Phys/Qhp 2-12 Hr W/Veeg	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	$Ambulatory\ or\ Video\ Electroence phalogram\ (EEG)\ Monitoring,\ Including\ Digital\ Analysis\ of\ Electroence phalogram$		_
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	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	
95722		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008		-	
	Eeg Phy/Qhp>36<60 Hr W/Veeg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	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	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
95803	Actigraphy Testing	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.048	Actigraphy		
93803	Actigraphy resting	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	WED201.048	Actigraphy	_	_
95905	Motor &/ Sens Nrve Cndj Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.033	Automated Point-of-Care Nerve Conduction Testing	_	_
95954	Eeg Monitoring/Giving Drugs	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
95957	Eeg Digital Analysis	predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	_
95961	Electrode Stimulation Brain		MED205.011	Intraoperative Neurophysiologic Monitoring (IONM)		6/30/2022
		predetermination to avoid post-service review.	MED205.009	Topographic Brain Mapping (Quantitative Electroencephalography)	-	-,,
95962	Electrode Stim Brain Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.011	Intraoperative Neurophysiologic Monitoring (IONM)	-	6/30/2022
95962 95965		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.011 MED205.009 PSY301.014	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Mapping (Quantitative Electroencephalography) Autism Spectrum Disorders (ASD)	-	
95965	Meg Spontaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009 PSY301.014 RAD601.038 PSY301.014	Intraoperative Neurophysiologic Monitoring (IONM) Toposgrahlic Parian Magning (Lountitative Electroencephalography) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD)	-	
95965 95966	Meg Spontaneous Meg Evoked Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009 PSY301.014 RAD601.038 PSY301.014 RAD601.038	Intraoperative Neurophysiologic Monitoring (IOMM) Topographic Brain Mapping (Quantitative Electroencephalography) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	
95965	Meg Spontaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009 PSY301.014 RAD601.038 PSY301.014 RAD601.038	Intraoperative Neurophysiologic Monitoring (IONM) Toposgrahlic Parian Magning (Lountitative Electroencephalography) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD)	- - -	
95965 95966	Meg Spontaneous Meg Evoked Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED205.011 MED205.009 PSY301.014 RAD601.038 PSY301.014 RAD601.038 PSY301.014	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Magoing (Lounalitative Electroencephalography) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD)	-	
95965 95966 95967	Meg Spontaneous Meg Evoked Single Meg Evoked Each Addl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.011 MED205.009 PSY301.014 RAD601.038 PSY301.014 RAD601.038 PSY301.014	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Magoing (Lounalitative Electroencephalography) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Oisorders (ASD)	-	
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95965 95966 95967 95999 96000 96001 96002 96003 96004 96379 96549 96912 96931 96932 96934 96935 96936 96999 97139 97139 97170 97171	Meg Spontaneous Meg Evoked Single Meg Evoked Each Addl Neurological Procedure Motion Analysis Video/3D Motion Test W/Ft Press Meas Dynamic Surface Emg Dynamic Fine Wire Emg Phys Review Of Motion Tests Ther/Prop/Diag Inj/Inf Proc Chemotherapy Unspecified Photochemotherapy With Uv-A Or B Laser Tx Skin >500 Sq Cm Rcm Celuir Subceluir Img Skn Rcm Celuir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to preservice reviewed against Medical Policy Criteri	MED205.011 MED205.019 PSY301.014 RAD601.038 PSY301.014 RAD601.038 - THE801.009 THE803.009 THE804.003 THE805.006 THE806.009 THE806.009 THE807.009 T	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Fain Mapping (Lountiative Electroencephalography) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) ———————————————————————————————————		6/30/2022
95965 95966 95967 95999 96000 96001 96002 96003 96004 96379 96549 96912 96931 96932 96933 96934 96935 96936 96999 97024 97039 97169 97171	Meg Spontaneous Meg Evoked Single Meg Evoked Each Addl Neurological Procedure Motion Analysis Video/3D Motion Test W/Ft Press Meas Dynamic Surface Emg Dynamic Fine Wire Emg Phys Review Of Motion Tests Ther/Prop/Diag Inj/Inf Proc Chemotherapy Unspecified Photochemotherapy With Uv-A Photochemotherapy Uv-A Or B Laser Tx Skin >500 Sq Cm Rcm Celuir Subcelulr Img Skn Active State Skn Dermatological Procedure Diathermy Eg Microwave Physical Therapy Treatment Physical Medicine Procedure Athletic Trn Eval Low Cmplx Athletic Trn Eval High Cmplx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to predetermination	MED205.011 MED205.019 PSY801.014 RAD601.038 PSY801.014 RAD601.038 PSY801.014 RAD601.038 - THE803.009 THE803.009 THE803.009 MED205.006 THE801.033 THE801.033 THE801.023 MED201.023	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Rain Mapoing (Lountiative Electroencephalography) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MS) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MS) Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MS)		6/30/2022

97610	Low Frequency Non-Thermal Us	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding DME101.044	Ultrasound Wound Therapy	_	_
97799	Physical Medicine Procedure	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to			
		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
99024	Postop Follow-Up Visit	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_
99026	In-Hospital On Call Service	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_
99027	Out-Of-Hosp On Call Service	review.	-	-	-
99050	Medical Services After Hrs	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
99056	Med Service Out Of Office	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_
99058	Office Emergency Care	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_
99070	Special Supplies Phys/Qhp	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_
99071	Patient Education Materials	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
33073	Wedical restillorly	Unlisted: Procedure/service not specifically defined or classified	-	-	-
99078	Group Health Education	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
99080	Special Reports Or Forms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
99082	Haustal Physician Travel	Unlisted: Procedure/service not specifically defined or classified Unlisted: Procedure/service not specifically defined or classified, may be subject to			
	Unusual Physician Travel	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require PSY301.014	- Autor Courter (ACD)	-	-
99183	Hyperbaric Oxygen Therapy	Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	Autism Spectrum Disorders (ASD)	-	-
99199	Special Service/Proc/Report	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
99360	Physician Standby Services	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		1/1/2021	_
99453	Rem Mntr Physiol Param Setup	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_
99454	Rem Mntr Physiol Param Dev	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u>-</u>		_
99455	Work Related Disability Exam	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u>-</u>		_
99456		review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u>-</u>	-	_
	Disability Examination	review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_
99457	Rem Physiol Mntr 1St 20 Min	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_
99491	Chrnc Care Mgmt Svc 30 Min	review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-
99499	Unlisted E&M Service	Contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-
99600	Home Visit Nos	contract/clinical review.	-	-	-
0052U	Lpoprtn Bld W/5 Maj Classes	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
0054T	Bone Srgry Cmptr Fluor Image	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR705.023 Policy (CPCP).	Computer-Assisted Navigation for Orthopedic Procedures	-	-
0055T	Bone Srgry Cmptr Ct/Mri Imag	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-
0062U	Ai Sle Igg&Igm Alys 80 Bmrk	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.159 Policy (CPCP).	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 PSY301.014	Autism Spectrum Disorders (ASD)		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	, , , , , , , , , , , , , , , , , , , ,	-	
0066U	Pamg-1 la Cervico-Vag Fluid	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	-	-
0075T	Perq Stent/Chest Vert Art	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	Endovascular Therapies for Extracranial Vertebral Artery Disease		_
0084U	Rbc Dna Gnotyp 10 Bld Groups	Predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	_
0086U		review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-
	Nfct Ds Bact&Fng Org Id 6+	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-
0087U	Crd Hrt Trnspl Mrna 1283 Gen	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
U8800	Trnsplj Kdn Algrft Rej 1494	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
0089U	Onc Mlnma Prame & Linc00518	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 Circt Scr Whi Bid Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
0092U	Onc Lng 3 Prtn Bmrk Plsm Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-
0093U	Rx Mntr 65 Com Drugs Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
0094U	Genome Rapid Sequence Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
0095U	Inflm Ee Elisa Alys Alg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_	_
0096U	Hpv Hi Risk Types Male Urine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_
0097U	Gi Pathogen 22 Targets	review Non Covered: Procedure/service may not covered by the Plan			_
0098U	Respir Pathogen 14 Targets	Procedure/service reviewed against Medical Policy Criteria. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			3/31/2021
0099U		review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	
00390	Respir Pathogen 20 Targets	review. – EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-	3/31/2021
0100T	Prosth Retina Receive&Gen	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR713.026 Policy (CPCP).	Retinal Prosthesis	-	-
		, ,.			

0100U	Respir Pathogen 20 Targets	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		3/31/2021
		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		
0101T	Extracorp Shockwv Tx Hi Enrg	Folicy (CPCP) Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-
0101U	Hered Colon Ca Do 15 Genes	review. — EIU: Procedure/service not covered by the Plan. Not subject to pre-service — EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	_
0102T	Extracorp Shockwv Tx Anesth	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR705.018 Policy (CPCP).	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 Ckd Mult Eclia Tum Nec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_
0106T	Touch Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED205.030 Policy (CPC).	Quantitative Sensory Testing _	-
0106U	Gstr Emptg 7 Timed Brth Spec	EIU: Procedure/service not relimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.017 Policy (CPCP).	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 MED205.030 Policy (CPC).	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 MED205.030 Policy (CPCP).	Quantitative Sensory Testing _	-
0108U	Gi Barrett Esoph 9 Prtn Bmrk	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_
0109T	Heat Quant Sensory Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED205.030	Quantitative Sensory Testing	-
0109U	Id Aspergillus Dna 4 Species	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
0110T	Nos Quant Sensory Test	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 MED205.030	Quantitative Sensory Testing	_
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u> </u>	_
0111U	Onc Colon Ca Kras&Nras Alys	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
0112U	ladi 16S&18S Rrna Genes	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
0113U	Onc Prst8 Pca3&Tmprss2-Erg	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-
0114U	Gi Barretts Esoph Vim&Ccna1	review		-
0115U	Respir ladna 18 Viral&2 Bact	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	<u>-</u>	_
0116U	Rx Mntr Nzm Ia 35+Oral Flu	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_
0117U	Pain Mgmt 11 Endogenous Anal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_
0118U	Trnsplj Don-Drv Cll-Fr Dna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_
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 Whl Blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
0123U	Mchnl Fragility Rbc Prflg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-
0129U	Hered Brst Ca Ritd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		_
0130U	Hered Colon Ca Do Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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 Ritd Do Pni 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		_
0135U	Hered Gyn Ca Mrna Pnl 12 Gen	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
0136U	Atm Mrna Seg Alvs	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
0137U	Palb2 Mrna Seq Alys	review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-
01370 0138U	Brca1 Brca2 Mrna Seq Alys	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
01390	Neuro Austm Meas 6 C Metablt	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 PSY301.014	Autism Spectrum Disorders (ASD)	9/30/2021
		Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
0140U	Nfct Ds Fungi Dna 15 Trgt	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
0141U	Nfct Ds Bact&Fng Gram Pos	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
0142U	Nfct Ds Bact&Fng Gram Neg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
0143U	Drug Assay 120+ Rx/Metablt	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		_
0151U	Nfct Bct/Vir Resp Nfctj 33	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		3/31/2022
0152U	Nfct Ds Dna Untrgt Ngnrj Seq	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
0153U	Onc Breast Mrna 101 Genes	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
0154U	Onc Urthl Ca Rna Fgfr3 Gene	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-
0155U		review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-
	Onc Brst Ca Dna Pik3Ca Gene	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	_	_	_
0161U	Pms2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_
0162U	Hered Colon Ca Trgt Mrna Pnl	review. — — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		
0191T	Insert Ant Segment Drain Int	review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR713.034	Aqueous Shunts and Stents for Glaucoma	5/1/2021	12/31/2021
01911	insert Ant Segment Drain int	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Aqueous Situits and Steffs for Gradulina	5/1/2021	12/31/2021
0198T	Ocular Blood Flow Measure	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OTH903.022 Policy (CPCP).	Ophthalmologic Techniques For Evaluating Glaucoma	-	-
0202T	Post Vert Arthrplst 1 Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR712.034 Policy (CPCP).	Facet Arthroplasty	-	-
0207Т	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 OTH903.025 Policy (CPCP).	Eyelid Thermal Pulsation	-	-
0219T	Plmt Post Facet Implt Cerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR712.032 Policy (CPCP).	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 SUR712.032 Policy (CPCP).	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 SUR712.032	Isolated Facet Joint Fusion	-	-
0222Т	Plmt Post Facet Implt Addl	Policy (CPCP). EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR712.032	Isolated Facet Joint Fusion	_	_
0232T	Njx Platelet Plasma	Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service RX501.101 review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding 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	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR713.034	Acueous Shunts and Stents for Glaucoma		
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service SUR703.051	Aqueous Shunts and Stents for Glaucoma Orthopedic Applications of Stem-Cell Therapy	-	_
0263T	Im B1 Mrw Cel Ther Cmpl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR703.048 Policy (CPCP) EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service SUR703.051	Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
0264T	Im B1 Mrw Cel Ther Xcl Hrvst	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
0265T	Im B1 Mrw Cel Ther Hrvst Onl	EIU- Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	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 MED201.040 Policy (CPCP).	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 SUR701.039 Prior Authorization per contract agreement.	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 SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	_
0315T	Rmvl Vagus Nerve Pls Gen	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	
0316T	Replc Vagus Nerve Pls Gen	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	-
0317T	Elec Alys Vagus Nrv Pls Gen	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		2/15/2021	-
0330T	Tear Film Img Uni/Bi W/I&R	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OTH903.025 Policy (CPCP).	Eyelid Thermal Pulsation	-	-
0331T	Heart Symp Image Pinr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	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 SUR705.027 Policy (CPCP).	Subtalar Arthroereisis (STA)	-	-
0338T	Trnscth Renal Symp Denry 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 SUR701.030 Policy (CPCP).	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0339Т	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 SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	_
0347T	Ins Bone Device For Rsa	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RAD601.054 Relate (CPCP)	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0348T	Rsa Spine Exam	Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0349T	Rsa Upper Extr Exam	Policy (PCPC). EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	_	_
0350T	Rsa Lower Extr Exam	Policy (PCPC). EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0352T	Oct Brst/Node I&R Per Spec	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RAD601.053	Optical Coherence Tomography of the Breast		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RAD601.053		-	-
0354T 0355T	Oct Breast Surg Cavity I&R Gi Tract Capsule Endoscopy	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 RAD601.042	Optical Coherence Tomography of the Breast Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	-	12/31/2021
0358T	Bia Whole Body	Teview. Check EU policy CPCPUs, which is one of our Clinical Payment and Coding File Procedure/service not removed by the Pilan. Not subject to pre-service File Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service File EU Procedure/service not removed by the Pilan. Not subject to pre-service not remove the Pilan. File EU Procedure/service not remove the Pilan. File EU Procedure/s	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA)	-	
0376T	Insert Ant Segment Drain Int	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR713.034	write Body Composition Analysis using Dual X-ray Absorptiometry (DXA) or bloelectrical impedance Analysis (BIA) Aqueous Shunts and Stents for Glaucoma	_	12/31/2021
0378T		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	***************************************	-	V- V-22-
	Visual Field Assmnt Rev/Rprt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.044 Policy (CPCP) EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Home-Based Monitoring of Visual Field	-	-
0379T	Vis Field Assmnt Tech Suppt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.044 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Home-Based Monitoring of Visual Field	-	-
0397T	Ercp W/Optical Endomicroscpy	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.038 Policy (CPCP). MP Criteria. Procedure/service reviewed against Medical Policy Criteria. Submit for	Confocal Laser Endomicroscopy (CLE)	-	-
0398T	Mrgfus Strtctc Les Abltj	predetermination to avoid post-service review.	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 EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Corneal Collagen Cross-Linking	-	6/30/2022
0423T	Assay Secretory Type Ii Pla2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.134 Policy (CPCP).	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	-	12/31/2021
0424T	Insj/Rplc Nstim Apnea Compl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR701.042 Policy (CPCP).	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 Stm Ld	POICY (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0427T	Insj/Rplc Nstim Apnea Pls Gn	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0428T	Rmvl Nstim Apnea Pls Gen	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	
	<u> </u>	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
0429T	Rmvl Nstim Apnea Sen Ld	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR/01.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0430T	Rmvl Nstim Apnea Stimj Ld	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0431T	Rmvl/Rplc Nstim Apnea Pls Gn	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 Npgs Apnea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0435T	Prgrmg Eval Npgs Apnea 1 Ses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0436T	Prgrmg Eval Npgs Apnea Study	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0444T		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Drus Studios Introcanalicular Bunetal Bluer and Orular Incerte		
	1St Plmt Drug Elut Oc Ins	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	-
0445T 0449T	Sbsqt Plmt Drug Elut Oc Ins	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.035 SUR713.034	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts Anuerus Shunts and Stents for Glauroma	-	-
04491	Insj Aqueous Drain Dev 1St	predetermination to avoid post-service review.			-	_
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 Njx 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 Skn Img Acquisj I&R 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	_
0471T	Oct Skn Img Acquisi I&R Addl	<u>predetermination to avoid post-service review.</u> MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	
54721	Jan mig regulaj laki Addi	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-3/ 1/1021	_
0472T	Prgrmg Io Rta Eltrd Ra	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR713.026	Retinal Prosthesis	-	-
0473T	Reprgrmg Io Rta Eltrd Ra	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	Fxjl 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	Fxjl 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	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	-	-
0493T	Near Ifr Spectrsc Of Wounds	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.006	Foot Care Services	-	_
0499T	Cysto F/Urtl Strix/Stenosis	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR710.026	Optilume (Drug Coated Balloon) for the Treatment of Urethral Stricture Conditions	_	-
0507T	Near Ifr 2Img Mibmn Glnd I&R	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.025	Eyelid Thermal Pulsation	_	_
0508T	Pls Echo Us B1 Dns Meas Tib	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RAD601.071	Pulse-Echo Ultrasound Bone Density Measurement		
0509T	Pattern Erg W/I&R	Policy (CPCP). 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	ULHOUS use	Flortroretinggraphy (ERG), Multi-Engal Flortroretinggraphy (mfERG), And Dathers Flortroretinggraphy (DERG)	5/15/2021	
		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	3/ 13/ 2021	-
0511T	Rmvl&Rinsj Sinus Tarsi Implt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Subtalar Arthroereisis (STA)	-	-
0512T	Esw Integ Wnd Hig 1St Wnd	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0513T	Esw Integ Wnd Hlg Ea Addl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0524T	Ev Cath Dir Chem Abltj W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	4/1/2021	_
0533T	Cont Rec Mvmt Do 6-10 Days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0534T	Cont Rec Mvmt Do Setup&Train	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0535T	Cont Rec Mvmt Do Reprt Cnfig	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0536T	Cont Rec Mvmt Do DI W/I&R	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	-
0548T	Tprnl Balo Cntnc Dev Bi	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.036	Implanted Adjustable Continence Therapy	_	12/31/2021
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				12/31/2021
0549T	Tprnl Balo Cntnc Dev Uni	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.036	Implanted Adjustable Continence Therapy	-	,,
0549T 0550T	Tprnl Balo Cntnc Dev Uni Tprnl Balo Cntnc Dev Rmvl Ea	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Implanted Adjustable Continence Therapy	_	12/31/2021

63T EV 65T AL 65T AL 65T AL 66T AL 66T AL 66T AL 66T AL 66T AL 66T TEL		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). 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). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed against Medical Policy Criteria.	CPCP028 SUR703.051 SUR703.051 SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) Percutaneous Tibial Nerve Stimulation (PTNS)	8/15/2021	- 8/14/2021 - 8/14/2021 - 8/14/2021
65T At 65	utol Cell Impit Adps Hrvg utol Cell Impit Adps Hrvg utol Cell Impit Adps Njx utol Cell Impit Adps Njx erg Impiti/Rpicmt Isdns Ptn evision/Removal Isdns Ptn lec Alys Smpl Prgrmg lins lec Alys Cplx Prgrmg lins	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU Dolicy CPCD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUD policy CPCD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUD policy CPCD9. Which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.051 SUR703.051 SUR703.051 SUR703.051 MED205.035	Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) Percutaneous Tibial Nerve Stimulation (PTNS)	8/15/2021 4/1/2021 8/15/2021	-
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### ALL PROPERTY OF THE PROPER	utol Cell Impit Adps Njx utol Cell Impit Adps Njx erq Impiti/Rpicmt Isdns Ptn evision/Removal Isdns Ptn lec Alys Smpl Prgrmg lins lec Alys Cplx Prgrmg lins	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). 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). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.051 SUR703.051 MED205.035	Marrow) Orthopedic Applications of Stem Cell Therapy (including Allografts and Bone Substitutes Used with Autologous Bone Marrow) Orthopedic Applications of Stem Cell Therapy (including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) Percutaneous Tibial Nerve Stimulation (PTNS)	4/1/2021 8/15/2021	- 8/14/2021 -
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PET PET TO PET T	erq Implti/Rpicmt Isdns Ptn evision/Removal Isdns Ptn lec Alys Smpl Prgrmg Iins lec Alys Cpix Prgrmg Iins	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.035	Marrow) Percutaneous Tibial Nerve Stimulation (PTNS)		-
REPORT FOR THE PROPERTY OF THE	lec Alys Smpl Prgrmg lins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.			3/1/2021	
DT Ele DT Ele Tr Tr Tr ST Ey	lec Alys Smpl Prgrmg lins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.035			_
0T Eld 2T Tr 3T Tr 5T Ey	lec Alys Cplx Prgrmg lins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	_
DT EIA 2T Tr 3T Tr 5T Ey	lec Alys Cplx Prgrmg lins		MED205.035		3/1/2021	
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iT Ey		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	MED201.050		4/1/2021	_
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OT Ev		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	-
	vasc Ven Artiz Tibl/Prnl Vn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
1T Tr		EIU: Procedure/service not reimbursed 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	-
2T Tr	rabeculostomy Int Lsr W/Scp	Folicy (CPCP). EUC: Procedure/service not reimbursed 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	-
IT AL	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	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	_
IT AL	uto Quan C Plaq Data Prep	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	_
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	auto Quan C Plag I&R	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032		1/1/2021	
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T Pe	erq Njx Algc Fluor Lmbr 1St	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
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T Pe	erq 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	-
)T P∈	erq 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	-
LT To	c Vis Lit Hyperspectral Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
2T P€	erq Tcat Us Abltj Nrv P-Art	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
9T W	Vrls 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	-
OT No	Icntc Nr Ifr Spctrsc Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	_
1T No	Icntc Nr Ifr Spctrsc Wnd Img	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
T No	Icntc Nr Ifr Spctrsc Wnd I&R	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
IT To	cat 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	-
т то	cat Impltj C Sins Rdctj 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	-
T Tt	tvi/Rplcmt W/Prstc Vlv 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	_
T Pr	rgrmg 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	_
T Vr	rt 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	SUR705.046		7/1/2021	_
7T Vr	rt Bdy Tethering Ant 8+ Seg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	7/1/2021	_
BT Ele	lec Impd Spectrsc 1+Skn Les	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for procedure against Medical Policy Criteria.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	_
T Do	Oon Hysterectomy Open Cdvr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023		7/1/2021	8/14/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding			8/15/2021	_
	Oon Hysterectomy Open Liv	Policy (CPCP). 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
oT Do	on 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	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	_
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
ST Do	on Hysterectomy Laps Liv					
5T Do	on Hysterectomy Laps Liv	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			8/15/2021	-
55T Do	on Hysterectomy Laps Liv	predetermination to avoid post-service review. EIU: Procedure/ service not reimbused by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021	- 8/14/2021
De D	on Hysterectomy Laps Liv on Hysterectomy Laps Liv on Hysterectomy Rop Uter	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).	OB402.023	Services for Infertility and Recurrent Fetal Loss Services for Infertility and Recurrent Fetal Loss		8/14/2021
555T Do 566T Do 566T Do 567T Do 577T Do	on Hysterectomy Laps Liv on Hysterectomy Laps Liv on Hysterectomy Rcp Uter	predetermination to avoid post-service review. EU: Procedure/service not reimbused by the Plan. Not subject to pre-service review. Check EU policy C PCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbured by the Plan. Not subject to pre-service	OB402.023	Services for Infertility and Recurrent Fetal Loss Services for Infertility and Recurrent Fetal Loss Services for Infertility and Recurrent Fetal Loss	7/1/2021	- 8/14/2021 - 8/14/2021

0669T	Bkbench Rcnstj Don Uter Ven	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. OB402.02	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0669T	Bkbench Rcnstj Don Uter Ven	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OB402.02	Services for Infertility and Recurrent Fetal Loss	8/15/2021	
		Policy (CPCP). MR Citheia: Procedure (consider reviewed against Medical Bolicy Citheia: Submit for			-
0670T	Bkbench Rcnstj Don Uter Artl	predetermination to avoid post-service review. OB402.02	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 Elly policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	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.	ODS 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.	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.	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.	ODS Ambulance and Medical Transport Services	_	_
A0436	Rotary Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for ADM1001	005 Ambulance and Medical Transport Services	_	_
A0888	Noncovered Ambulance Mileage	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for ADM1001	005 Ambulance and Medical Transport Services	_	
A0999	Unlisted Ambulance Service	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			
A2001	Innovamatrix Ac Per Sq Cm	contract/clinical review. = - EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.0	- 1 Amniotic Membrane and Amniotic Fluid	2022-04-15	_
A2002	· ·	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	A Australia Manhara and Australia Field	4 (45 (2022	4/44/2022
A2002	Mirragen adv wnd mat per sq	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1 Amniotic Membrane and Amniotic Fluid	1/15/2022	4/14/2022
A2002	Mirragen adv wnd mat per sq	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.0 Policy (CPCP).	1 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.	1 Amniotic Membrane and Amniotic Fluid	1/15/2022	4/14/2022
A2004	Veallisters per co on	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1 Amniotic Membrane and Amniotic Fluid	4/15/2022	
A2004	Xcellistem per sq cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.0 Policy (CPCP).	1 Annihout Memorane and Annihout 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. SUR704.0	1 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 SUR704.0 Policy (CPCP)	1 Amniotic Membrane and Amniotic Fluid	4/15/2022	-
A2006	Novosorb synpath per sq cm	Policy (EPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	1 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 SUR704.0	1 Amniotic Membrane and Amniotic Fluid	4/15/2022	-
A2007	Restrata per sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR704.0	1 Amniotic Membrane and Amniotic Fluid	1/15/2022	4/14/2022
A2007	Postrata par sa em	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		4/15/2022	
	Restrata per sq cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.0 Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-
A2008	Theragenesis per sq cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	1 Amniotic Membrane and Amniotic Fluid	1/15/2022	4/14/2022
A2008	Theragenesis per sq cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.0 Policy (CPCP).	1 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.	1 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 SUR704.0	1 Amniotic Membrane and Amniotic Fluid	4/15/2022	
		Policy (CPCP).		4/15/2022	-
A2010	Apis per square centimeter	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. SUR704.0		1/15/2022	4/14/2022
A2010 A2010	Apis per square centimeter Apis per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR704.0	1 Amniotic Membrane and Amniotic Fluid		- 4/14/2022 -
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding 87704.0	Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid	1/15/2022	- 4/14/2022 -
A2010	Apis per square centimeter	MP Citheria: 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 CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding SUR704.0	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022	- 4/14/2022 - -
A2010	Apis per square centimeter Supra Sdrm Per Sq Cm	MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Sur704.0	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022	- 4/14/2022 - - -
A2010 A2011 A2012	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service preview. Check EIU policy CPC98, which is one of our Clinical Payment and Coding Policy (CPCP).	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022	- 4/14/2022 - - -
A2010 A2011 A2012 A2013	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos	MP Citeria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIÜ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIÜ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIÜ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIÜ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIÜ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). SUR704.0 Policy (CPCP). Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08.	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	- 4/14/2022 - - - - - - - 12/31/2022
A2010 A2011 A2012 A2013 A4100 A4267 A4290	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom Sacral Nerve Stim Test Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not ceimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC98, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC98, which is one of our Clinical Payment and Coding Policy (CPCP). Not Correred: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPC98, which is one of our Clinical Payment and Coding Policy (CPCP). Not Correred: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPC98, which is one of our Clinical Payment and Coding Policy (CPCP). Not Correred: Procedure/service not covered by the Plan. Not subject to pre-service review.	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc	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 CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP0B, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require prior Authorization per contract agreement. Unisted: Procedure/service not specifically defined or classified, may be subject to pre-service portorate/felinical review.	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontrence Supply Ostomy Supply Misc Reusable Enema Bag	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not specifically defined or classified, may be subject to Contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to Contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, may be subject to review.	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458 A4520	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). FIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). SUR704.0 SUR7	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontrence Supply Ostomy Supply Misc Reusable Enema Bag	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). SUR704.0 SUR7	1 Amniotic Membrane and Amniotic Fluid 1 Amniotic Membrane and Amniotic Fluid 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 2 Bioengineered Skin and Soft Tissue Substitutes 3 Bioengineered Skin and Soft Tissue Substitutes 4 Bioengineered Skin and Soft Tissue Substitutes	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
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A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4575 A4600 A4639 A4641 A4649 A4890 A4913	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All Sizes Disposable Underpads Ca Tx E-Stim Electr/Transduc Hyperbaric O2 Chamber Disps Sieeve Inter Limb Comp Dev Infrared Ht Sys Repicmnt Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc	MP Criteria: Procedure/service netweed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not creimbursed by the	Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid Bioengineered Skin and Soft Tissue Substitutes Sacral Nerve Neuromodulation/Stimulation	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4600 A4639 A4641 A4649 A4890 A4891 A4891 A4927	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All Sizes Disposable Underpads Ca Tx E-Stim Electr/Transduc Hyperbaric O2 Chamber Disps Sieeve Inter Limb Comp Dev Infrared Ht Sys Replcmnt Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves Reusable Oral Thermometer	MP Criteria: Procedure/service net/service veriewed 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 EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered. Procedure/service not covered by the Plan. Not subject to pre-service review. Policy (CPCP). Non Covered. Procedure/service not covered by the Plan. Not subject to pre-service review. Policy (CPCP). Non Covered. Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Policy CPCP Non Covered by the Plan. Not subject to pre-service review. Policy CPCP Non Covered by the Plan. Not subject to pre-service review. Policy CPCP Non Covered Policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP09. Policy CPCP Non Covered Policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP09. Policy CPCP Non Covered Policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP09. Policy CPCP Non Payment Policy CPCP08, which is one of our Clinical Pay	Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid Bioengineered Skin and Soft Tissue Substitutes Sacral Nerve Neuromodulation/Stimulation	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4600 A4639 A4641 A4649 A4890 A4890 A4913 A4927 A4931	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Cird As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All Sizes Disposable Underpads Ca Tx E-Stim Electr/Transduc Hyperbaric O2 Chamber Disps Sieeve Inter Limb Comp Dev Infrared Ht Sys Replcmnt Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves	MP Criteria: Procedure/service net/service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid Bioengineered Skin and Soft Tissue Substitutes Sacral Nerve Neuromodulation/Stimulation	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-
A2010 A2011 A2012 A2013 A4100 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4555 A4600 A4639 A4641 A4649 A4890 A4913 A4927 A4931 A4932	Apis per square centimeter Supra Sdrm Per Sq Cm Suprathel Per Sq Cm Innovamatrix Fs Per Sq Cm Skin Sub Fda Clrd As Dev Nos Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All Sizes Disposable Underpads Ca Tx E-Stim Electr/Transduc Hyperbaric O2 Chamber Disps Sleeve Inter Limb Comp Dev Infrared Ht Sys Replcmnt Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves Reusable Oral Thermometer Reusable Rectal Thermometer	MP Criteria: Procedure/service netweed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Non Covered: Procedure/service reviewed against Medical Policy Criteria, may require review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP09. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/elinical review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/elinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service revi	Amniotic Membrane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid Bioengineered Skin and Soft Tissue Substitutes Sacral Nerve Neuromodulation/Stimulation	1/15/2022 4/15/2022 4/1/2022 4/1/2022 4/1/2022	-

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 $$	_	_	_	_
40453		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
A9152	Single Vitamin Nos	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 Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
A9270	Non-Covered Item Or Service	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
A9273	Hot/Cold Botle/Cap/Col/Wrap	review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
A9279	Monitoring Feature/Devicenoc	contract/clinical review.	_	-	-	-
A9280	Alert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	F	-	-
A9282	Wig Any Type	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.	_	_	7/1/2022	_
		Unlisted: Procedure/service not specifically defined or classified EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
A9285	Inversion Eversion Cor Devic	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	PSV302 002	Digital Health Therapies for Substance Abuse	2022-04-01	
N3231	Tres digital belief fried rad	Policy (CPCP).	1 31302.002	Digital Health The Lapies 10. Substance Abose	1011 04 01	
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
A9515	Choline C-11	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	contract/clinical review. 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	_	_	_	_
A9900	Supply/Accessory/Service	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		-		
A9999		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		-		-
	Dme Supply Or Accessory Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		-	-	-
B4105	Enzyme Cartridge Enteral Nut	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	MED201.011	Nutritional Support	-	6/30/2022
B9998	Enteral Supp Not Otherwise C	contract/clinical review.	-	-	-	-
B9999	Parenteral Supp Not Othrws C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
C1052	Hemostatic Agent Gi Topic	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	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	_
C1761		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			2021-07-01	
	Cath Trans Intra Litho/Coro	predetermination to avoid post-service review. MP Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and	2021-07-01	-
C1764	Event Recorder Cardiac	predetermination to avoid post-service review.	MED202.003	Intracardiac Ischemia Detection Systems)	-	-
1		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.024	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	-	-
C1776 C1783	Joint Device (Implantable) Ocular Imp Aqueous Drain De	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.024 SUR713.034		-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	_ _ _	- -
C1783	Ocular Imp Aqueous Drain De	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid nost-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR713.034 OTH903.030	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma	- - - 4/1/2022	-
C1783 C1818 C1823	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.034 OTH903.030 SUR701.042	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea		- - -
C1783 C1818 C1823 C1825	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034 OTH903.030 SUR701.042 THE801.034	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices	2/1/2021	-
C1783 C1818 C1823	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034 OTH903.030 SUR701.042	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea	2/1/2021	- - -
C1783 C1818 C1823 C1825	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCPDs, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Liu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCPDs, which is one of our Clinical Payment and Coding	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and	2/1/2021	-
C1783 C1818 C1823 C1825 C1825 C1841	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service Policy (CPCP).	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	-
C1783 C1818 C1823 C1825 C1833	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Amb Criteria: Procedure/service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	2/1/2021	- - - -
C1783 C1818 C1823 C1825 C1825 C1841	Ocular Imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid opst-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimboursed by the Plan. Not subject to pre-service review. Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 -	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - -
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - - - - - - -
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/insert Device Noc Cath Translumin Drug-Coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid nost-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Plan: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR701.041 SUR701.028 SUR701.027	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - - - - - - - - - - -
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthrits of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Exchemia Detection Systems) Retinal Prosthesis Retinal Prosthesis - Endovascular Therapies for Extracranial Vertebral Artery Disease Extracranial Cardid Angioplasty or Stenting	2/1/2021	- - - - - - - - - - - - - -
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/insert Device Noc Cath Translumin Drug-Coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). Unistest: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR701.041 SUR701.028 SUR701.027	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - - - - - - - - - - -
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPDB, which is one of our Clinical Payment and Coding Policy (CPCP). Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR701.041 SUR701.028 SUR701.027	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthrits of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - - 6/30/2022
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624 C2698	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor Brachytx Stranded Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPO8, which is one of our Clinical Payment and Coding Policy (CPCP). Eli: Procedure/service not septifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR701.041 SUR701.028 SUR701.027	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthrits of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021	- - - - - - - 6/30/2022 - - - 3/31/2021
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624 C2698 C2699	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor Brachytx Stranded Nos Brachytx Non-Stranded Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Check Ell policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPO8, which is one of our Clinical Payment and Coding Policy (CPCP). Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCPO8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthrits of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation for Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Exchemia Detection Systems) Retinal Prosthesis Retinal Prosthesis	2/1/2021 2022-01-01 - - - -	-
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C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624 C2698 C2699 C9072 C9073	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor Brachytx Stranded Nos Brachytx Non-Stranded Nos Inj Imm Glob Asceniv Brexucabtagene Autoleucel Ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria:	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation For Central Sleep Apnea Baroreflex Stimulation Devices Long-Trem Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021 2022-01-01 2/1/2021 2/1/2021	- - - 3/31/2021 3/31/2021
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C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624 C2698 C2699 C9072 C9073 C9074 C9081 C9085 C9092 C9093 C9094	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor Brachytx Stranded Nos Brachytx Non-Stranded Nos Inj imm Glob Asceniv Brexucabtagene Autoleucel Ca Injection Lumasiran Idecabtagene car pos t Inj Avalglucosid Alfa-Ngpt Inj. Xipere 1 Mg Inj. Susvimo 0.1 Mg Inj sutimlimab-jome 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unitsted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation For Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021 2022-01-01 2/1/2021 2/1/2021 5/1/2021 10/1/2021 1/1/2022 2022-04-01 7/1/2022	3/31/2021 3/31/2021 6/30/2021 12/31/2021 - 6/30/2022
C1783 C1818 C1823 C1825 C1825 C1833 C1841 C1842 C1889 C2623 C2624 C2698 C2699 C9072 C9073 C9074 C9081 C9085 C9092 C9093 C9094 C9097	Ocular imp Aqueous Drain De Integrated Keratoprosthesis Gen Neuro Trans Sen/Stim Gen Neuro Carot Sinus Baro Cardiac Monitor Sys Retinal Prosth Int/Ext Comp Retinal Prosth Add-On Implant/Insert Device Noc Cath Translumin Drug-Coat Wireless Pressure Sensor Brachytx Stranded Nos Brachytx Stranded Nos Inj Imm Glob Asceniv Brexucabtagene Autoleucel Ca Injection Lumasiran Idecabtagene car pos t Inj Avalglucosid Alfa-Ngpt Inj. Xipere 1 Mg Inj. Susvimo 0.1 Mg Inj sutimlimab-jome 10 mg Inj faricimab-svoa 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Eli: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service reviewed. Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Eli Dolicy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). Eli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Eli Dolicy CPCPD8, which is one of our Clinical Payment and Coding Policy (CPCP). Unitsted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clin	SUR713.034 OTH903.030 SUR701.042 THE801.034 MED202.003 SUR713.026 SUR713.026 SUR713.026	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Aqueous Shunts and Stents for Glaucoma Keratoprosthesis Phrenic Nerve Stimulation For Central Sleep Apnea Baroreflex Stimulation Devices Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) Retinal Prosthesis	2/1/2021 2022-01-01 2/1/2021 2/1/2021 5/1/2021 10/1/2021 1/1/2022 2022-04-01 7/1/2022	3/31/2021 3/31/2021 6/30/2021 12/31/2021 - 6/30/2022

C9356	Tenoglide Tendon Prot Cm2	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9358	Dermal Substitute Native Non- Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	-	-
C9359	Implnt,bon void filler-putty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	4/1/2021	-
C9360	Surgimend Neonatal	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.	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	SUR710.023	Prostatic Urethral Lift	_	_
C9740	Cysto Impl 4 Or More	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.023	Prostatic Urethral Lift		
C9757		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.045		2022-05-01	2022-07-31
C9757	Spine/Lumbar Disk Surgery	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	30K703.043	Annulus Closure After Discectomy	2022-03-01	2022-07-31
C9757	Spine/Lumbar Disk Surgery Revascularization, Endovascular,	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	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 Revascularization, Endovascular,	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	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	predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	-
C9768	Endo Us-Guide Hep Porto Grad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.043	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	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	SUR706.001	Nasal and Sinus Surgery	2/1/2021	5/14/2021
C9771	NsI/Sins Cryo Post Nasal Tis	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	SUR706.001	Nasal and Sinus Surgery	5/15/2021	-
C9772	Revasc lithotrip tibi/perone	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		mula	5/45/2024	0/44/2024
C9772	Revasc lithotrip tibi/perone	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	#N/A ADM1001.032	#N/A Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021 8/15/2021	8/14/2021
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
C9773	Revasc lithotr-stent tib/per	predetermination to avoid post-service review.	#N/A	#N/A	5/15/2021	8/14/2021
C9773	Revasc lithotr-stent tib/per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9774	Revasc lithotr-ather tib/per	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	#N/A	#N/A	5/15/2021	8/14/2021
C9774	Revasc lithotr-ather tib/per	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9775	Revasc lith-sten-ath tib/per	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	#N/A	#N/A	5/15/2021	8/14/2021
C9775	Revasc lith-sten-ath tib/per	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9777	Esophag Mucosal Integ Add-On	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	Inpt Implant Pros Dev No Cov	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D0999	Unspecified Diagnostic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_	_
D1705	AstraZeneca Covid-19 vaccine	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_		3/15/2021	_
D1706	administration -first dose AstraZeneca Covid-19 vaccine	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			3/15/2021	
	administration -second dose Unspecified Preventive Procedure	review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	3, 13, 2021	-
D1999	By Report	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	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	_	_
D4999	By Report Unspecified Periodontal Procedure By Report	contract/clinical review. 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	-	-	-	-
D5999	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.	-	-	_	-
		Unlisted: Procedure/service not specifically defined or classified, may be subject to				

	Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
D7210	Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated		•	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
D7220	Tissue	review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u> </u>	-	-
D7230	Partially Bony	review.		-	-
D7999		Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. – –		-	-
D8210		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		_	_
D8999	Unspecified Orthodontic Procedure	review. — — — — — — — — — — — — — — — — — — —			
	By Report Unspecified Adjunctive Procedure	contract/clinical review. — — — — — — — — — — — — — — — — — — —	<u> </u>		-
D9999		contract/clinical review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	•	-	-
E0210		review.	<u> </u>	-	-
E0217	Water Circ Heat Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	<u> </u>	-	_
E0218	Fluid Circ Cold Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. – –		-	_
E0221		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding DME101.045 Skin Contact Monochromatic Infrared Energy	(MIRE)		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-	_
E0231		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding DME101.050 Noncontact Normothermic Wound Therapy		_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
E0232		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding DME101.050 Noncontact Normothermic Wound Therapy Policy (CPCP).		-	-
E0236		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_
E0240		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_
		review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	•	-	-
E0241	Bath Tub Wall Rail	review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u> </u>	-	-
E0242	Bath Tub Rail Floor	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			
E0247	Trans Bench W/Wo Comm Open	review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u> </u>		_
		review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u> </u>	-	_
E0248	Hdtrans Bench W/Wo Comm Open	review.	<u> </u>		-
E0273		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-
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. Hospital Beds and Related Equipment predetermination to avoid post-service review.		_	_
E0315	Bed Accessory Brd/Tbl/Supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_
E0316		review.			
	Bed Safety Enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for DMF101.001 Hospital Reds and Related Equipment			
	Bed Sarety Enclosure	MP Criticia: Procedure/service reviewed against Medical Policy Criteria. Submit for pmE101.001 Hospital Beds and Related Equipment predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		-	_
E0446	Topical Ox Deliver Sys Nos	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to Ornerart / Unlisted: Proview		-	-
E0446 E0471	Topical Ox Deliver Sys Nos Rad W/Backup Non Inv Intrfc	prodetermination to avoid post-service review. UNILIDATED HOSPITATED HOSPITA		– – Moved to PA list	- - 6/30/2021
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E0676	Inter Limb Compress Dev Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	MED202.060 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	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E0692	Uvl Sys Panel 4 Ft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions	-	
E0693	Uvl Sys Panel 6 Ft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions	-	_
E0694	Uvl Md Cabinet Sys 6 Ft	predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	_
E0731	Conductive Garment For Tens/	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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	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	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Sacral Nerve Neuromodulation/Stimulation		
E0747		Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.026 SUR705.044	Surface Electrical Stimulation	-	-
	Elec Osteogen Stim Not Spine	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Electrical Bone Growth Stimulation of the Appendicular Skeleton	-	_
E0748	Elec Osteogen Stim Spinal	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR7U5.U13	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	-	-
E0749	Elec Osteogen Stim Implanted	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.044	Electrical Bone Growth Stimulation of the Appendicular Skeleton	-	-
E0760	Osteogen Ultrasound Stimltor	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	MED201.042	Electrical Stimulation for the Treatment of Arthritis	_	_
E0764	Functional Neuromuscularstim	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.033	Functional Neuromuscular Electrical Stimulation	1/1/2022	3/31/2022
EU/64	runctional Neuromuscularstim	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	WED201.033	Functional Neuroniuscular Electrical Stimulation	1/1/2022	3/31/2022
E0764	Functional Neuromuscularstim	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	MED201.033	Functional Neuromuscular Electrical Stimulation	4/1/2022	
		Policy (CPCP).			7/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/	-
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	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds		
20703	Liectric Would Treatment Dev	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified	WIED201.027	Electrostimulation and Electromagnetic Therapy for Treating Woulds	-	-
E0770	Functional Electric Stim Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	MED201.033	Functional Neuromuscular Electrical Stimulation	_	_
		contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				_
E0830	Ambulatory Traction Device	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	Track France Attack Headboard	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME101 046	Teation Devices for the in the Home		
EU04U	Tract Frame Attach Headboard	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	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
E0850	Traction Stand Free Standing	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	DME101.046	Traction Devices for Use in the Home	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
E0856	Cervic Collar W Air Bladders	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	-	-
E0860	Tract Equip Cervical Tract	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME101.046	Traction Devices for Use in the Home		
20800	Tract Equip Cervical Tract	Policy (CPCP).	DIVICIOI.040	Traction perices for use in the nome	-	-
E0890	Traction Frame Attach Pelvic		DME101.046	Traction Devices for Use in the Home	_	_
E0935	Cont Pas Motion Exercise Dev	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF101.023	Continuous Passive Motion (CPM) Device		6/30/2022
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	3, 23, 232
E0936	Cpm Device Other Than Knee	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	DME101.046	Traction Devices for Use in the Home		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				-
E0944	Pelvic Belt/Harness/Boot	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.046	Traction Devices for Use in the Home	-	-
E0985	W/C Seat Lift Mechanism	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E0986	Man W/C Push-Rim Powr System	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1002	Pwr Seat Tilt	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories Wheelchairs and Accessories	_	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
E1003	Pwr Seat Recline	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E1004	Pwr Seat Recline Mech	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E1005	Pwr Seat Recline Pwr	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	DME101.010	Wheelchairs and Accessories	_	_
E1012	Ctr Mount Pwr Elev Leg Rest	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1161	Manual Adult Wc W Tiltinspac	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1229	Pediatric Wheelchair Nos	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
E1230	Power Operated Vehicle	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	- Wheelchairs and Accessories	_	-
	. Swar Operated Vehicle	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.		THEOLOGICAL AND PAGE STATES	-	
E1239	Ped Power Wheelchair Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	-	-
E1399	Durable Medical Equipment Mi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-		-	_
E1629	Tablo For Dialysis Service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	2022-01-01	_
E1632	Wearable artificial kidney	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-position review.	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	7/1/2022	12/31/2022
E1622	Weership out for the	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	THE803 003	Delle Homedialerie and Homedialerie in the Provention	4/4/2022	
E1632	Wearable artificial kidney	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	I FEOUZ.UUZ	Daily Hemodialysis and Hemodialysis in the Home Setting	1/1/2023	-

The content							
	E1699	Dialysis Equipment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	-	_
Marie	F4700		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME103.009	Mechanical Stretching Devices		
Manual	E1700	Jaw Motion Rehab System		SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
	F1701	Real Cushions For Jaw Motion		DME103.009	Mechanical Stretching Devices		
Mater St. March St. Mar	21701	Repi Custilotis For Jaw Motion	Policy (CPCP).	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		-
	E1702	Reni Measr Scales Jaw Motion					
Mathematical			Policy (CPCP).			_	
Ministry	E1902	Aac Non-Electronic Board				_	_
300 Montany Montany Mark Mark Mark Mark Mark Mark Mark Mark	E2300	Pwr Seat Elevation Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
Section Comparison Compar	F2301	Pwr Standing		DMF101.010	Wheelchairs and Accessories		
Section Sect		-					
Windows Wind	E2310	Electro Connect Btw Control	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
Manual	E2311	Electro Connect Btw 2 Sys		DME101.010	Wheelchairs and Accessories	-	_
Section Sect	E2312	Mini-Prop Remote Joystick		DME101.010	Wheelchairs and Accessories	_	_
Marie Mari	E2313	Pwc Harness Expand Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
Section Sect		Hond Interface Investigis					
Marie					Milestrializ and Accessories	_	
Manual	E2322	Mult Mech Switches	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
Section Sect	E2323	Special Joystick Handle		DME101.010	Wheelchairs and Accessories	_	-
Market M	E2324	Chin Cup Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
Part	F2325	Sin And Puff Interface		DMF101 010	Wheelchairs and Accessories		
March Marc						_	
Manufaction		Breath Tube Kit	predetermination to avoid post-service review.		wheelchairs and Accessories	-	_
Michael Angle Michael Angl	E2327	Head Control Interface Mech	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
Marcan formation	E2328	Head/Extremity Control Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
18.00 18.0	E2329	Head Control Nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
Manufaction			,				
Manual			predetermination to avoid post-service review.			-	
West	E2331	Attendant Control	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
Mathematical Content	E2340	W/C Wdth 20-23 In Seat Frame		DME101.010	Wheelchairs and Accessories	-	-
Control Cont	E2341	W/C Wdth 24-27 In Seat Frame		DME101.010	Wheelchairs and Accessories	_	_
Marche M	E2342	W/C Dpth 20-21 In Seat Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
March Marc	E2242	W/C Park 22 25 to 5 t 5		D14F404 040	Which is and A second		
		W/C Dptn 22-25 in Seat Frame			wheelchairs and Accessories	_	
Weak	E2351	Electronic Sgd Interface	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
	E2373	Hand/Chin Ctrl Spec Joystick		DME101.010	Wheelchairs and Accessories	-	_
Second S	E2374	Hand/Chin Ctrl Std Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
Page	F2375	Non-Evnandable Controller		DME101.010	Wheelchairs and Accessories		
Page							
		Expandable Controller Repl			Wheelchairs and Accessories	_	
Second Content	E2377	Expandable Controller Initl	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
Separation Sep	E2500	Sgd Digitized Pre-Rec <=8Min		DME104.009	Speech Generating Devices (SGD)	_	_
Sep Process Page 2004	E2502	Sgd Prerec Msg >8Min <=20Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	_
	F2504	Sad Preser Msa>20Min <=40Min		DMF104 009	Speach Generating Devices (SCD)		
Section Sect						-	
September Procession September Sep	E2506	Sgd Prerec Msg > 40 Min	predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	_
Second Communication Communi	E2508	Sgd Spelling Phys Contact	predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	-
Sept	E2510	Sgd W Multi Methods Msg/Accs		DME104.009	Speech Generating Devices (SGD)	_	_
Sign Accessory Mounting Sign A	E2511	Sgd Sftwre Prgrm For Pc/Pda	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)		
Seed Accessory Noc. Wilstake Procedure framework and Conference and Seed Policy (Cortens, Submit for contract agriculture framework and procedure fra	E3E13						
Sign Accessory Note Unitative Procedure/Jervices of casaline/dumy he subject to present procedure proc	-2314	SPA Accessory Mounting SAs	predetermination to avoid post-service review.	SWILTU4.009	Special Generaling Devices (2007)	-	
Metal Wic Cushion More (Tentar: Procedure/ private network against Medical Policy Citatins Submit for	E2599	Sgd Accessory Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to	DME104.009	Speech Generating Devices (SGD)	-	-
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But Procedum/service not reimburd by the Plan. Not subject to pre-service review. Neek Ell publicy (PCPG), which is one of our Clinical Payment and Coding Procedum/service not covered by the Plan. Not subject to pre-service review.	G0235		contract/clinical review. May require PA per contract agreement.	-	-	-	-
MEDIA MEDI	G0255		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
review. —			Policy (CPCP).		Quantitative Sensory Testing	-	
Hot Full Body Chamber 30M PC Criteria: Procedure/Service reviewed against Medical Policy Citeria, may require 1 H1801.03 Puperbaric Oxygen (1802) Therapy Flex Stim Unattend For Press Policy (FCP)	G0276	Pild/Placebo Control Clin Tr	review.	-	-	-	-
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Policy (CPCP)	C0391	Floo Chim Unother 4 5 B	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201 027	Floatesetimulation and Floatesmannatic Thorons for Treating W.		
Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy (PCPD). Which is one of our Clinical Payment and Coding Payment	GU281	Elec Stim Unattend For Press	Policy (CPCP).	WED201.027	Electrostillulation and Electromagnetic Therapy for Treating Wounds	-	-
Policy (CPCP) Non-Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Service Servi	G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds		
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Felictromagnetic Therapy On: Fig. 19 Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (PCP). Fig. 19 Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (PCP). Fig. 19 Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP08, which is one of our Clinical Payment an	G0293	Non-Cov Surg Proc Clin Trial	review.	-	-	-	-
ELI: Procedure/service not reinbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP0s, which is one of our Clinical Payment and Coding Paymen	G0294	Non-Cov Proc Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_	_	_
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EIJ: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. A class EI policy (CPCP). Folicy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for policy (CPCP). G0341 Laparotomy Islet Cell Trans MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service review. G0452 Laparotomy Islet Cell Trans MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service review. G0462 The State Biopsy Any Mithd MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service review. G0472 The State Biopsy Any Mithd MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service review against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service review against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for proteiter-mination to a wold post-service reviewed against Medical Policy Criteria. Submit for THESO3.023 The Staturation and Electromagnetic Therapy For Treating Mounds The Staturation and Electromagnetic Therapy For Treating Mounds	G0295	Electromagnetic Therapy Onc	Policy (CPCP).			-	-
Policy (CPCP). The control of the co	G0329	Electromagntic Tx For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
predetermination to avoid post-service review. 60342 Laparoscopy islet Cell Trans MP Criteria: Procedure/service review. 60343 Laparotomy islet Cell Trans MP Criteria: Procedure/service review. MP Criteria: Procedure/service review. 60343 Laparotomy islet Cell Transplantation MP Criteria: Procedure/service review. MP Criteria: Submit for procedure/service review. MP Criteria: Submit for procedure/service review. MP Criteria: Procedure/service review. MP Criteria: Submit for procedure/service review. MP Criteria: Submit for procedure/service review. MP Criteria: Procedure/service review. MP Criteria: Submit for procedure/service rev			Policy (CPCP).	THE803.008	Non-Covered Physical Therapy Services		_
predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed. MP Criteria: P	G0341	Percutaneous Islet Celltrans		SUR703.013	Pancreas and Related Organ Tissue Transplantation	-	_
Laparotomy Islet Cell Transp MP Criteria: Procedure/Jeservice reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for produce mission to avoid post-service reviewed against Medical Policy Criteria. Submit for THESIAD.202 Cardiac Rehabilitation (CR) THESIAD.202 Cardiac Rehabilitation (CR)	G0342	Laparoscopy Islet Cell Trans		SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_
predetermination to avoid post-service review. G0416 Prostate Biopsy Any Mthd Priteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. G0422 Intens Cardiac Rehab W/Exerc G0423 Intens Cardiac Rehab W/Exerc G0424 Intens Cardiac Rehab W/Exerc MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for THE803.023 THE803.023 Cardiac Rehabilitation (CR)	G0343	Laparotomy Islet Cell Transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_
Prostate Biopsy. Any writing predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for THE803.023 THE803.023 Cardiac Rehabilitation (CR)						-	6/20/2022
GU422 Intens Cardiac Rehab W/Exerc I HE803.023 Cardiac Rehabilitation (CR)			predetermination to avoid post-service review.		Biopsy	-	0, 30, 2022
	GU422	intens Cardiac Rehab W/Exerc		1HE8U3.023	Carolac Kenadilitation (CK)	-	-

G0423	litteris Cardiac Reliab NO Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Cardiac Rehabilitation (CR)	-	-
C0430	Collagen Meniscus Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Martine I Illiano In and Other Martine I Institute		
G0428	Defects (F.G. Cmi, Collagen Scaffold	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR705.034 Policy (CPCP). PA maybe required until 04/01/2022.	Meniscal Allografts and Other Meniscal Implants	-	-
	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy				
G0429	Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Cosmetic and Reconstructive Procedures	-	-
	Therapy.)	AND COLOR DE LA CO			
G0455	recai Microbiota Prep Ilistii	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Fecal Microbiota Transplantation (FMT)	-	6/30/2022
G0460	Autologous Prp For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	_	_
G0465	Autolog Prp Diab Wound Ulcer	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	4/13/2021	3/31/2022
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-,,
G0465		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding RX501.034 Policy (CPCP).	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.	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 RX501.105	Esketamine Nasal Spray	_	4/15/2021
G2083		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.105	Esketamine Nasal Spray	08/01/2021	
G8395	Lvef>=40% Doc Normal Or Mild	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
G8396		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		
		review. — — — — — — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
G8397	Dil Macula/Fundus Exam/W Doc	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
G8399	Pt W/Dxa Results Document	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-
G8400	Pt W/Dxa No Results Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	•	-	-
G8404	LOW EXTERNITY NEUR EXAMI DOCUM	review.	-	-	-
G8405	LOW Externity Neur Not Perior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G8410	Eval On Foot Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G8415	Eval On Foot Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-
G8416	Pt Inelig Footwear Evaluatio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_
G8417	Calc Bmi Aby Un Param E/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	_
G8418	Calc Bmi Blw Low Param E/LI	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_
G8419		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_
G8420	Calc Bmi Norm Parameters	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		
G8421		review. — — — — — — — — — — — — — — — — — — —	-		
G8422		review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		12/31/2021
		review.	-	-	12/51/2021
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
	Docrev Cur Meds By Elig Clin	review.	-	-	-
G8427 G8428	Cur Meds Not Document	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review	-	-	-
G8428 G8430	Cur Meds Not Document	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service - review	- - -	- -	-
G8428 G8430	Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service - Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service - review	- - - -	-	-
G8428 G8430 G8431	Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. — — — — — — — — — — — — — — — — — — —	- - - -	- - -	- - - -
G8428 G8430 G8431 G8432	Doctrev Cur Meds By Eng Lin Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng Scr For Dep Not Cot Doc Rsn	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. - Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - -	- - - -	- - - -
G8428 G8430 G8431 G8432 G8433	Doctrev Cur Meds By Eng Lin Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng Scr For Dep Not Cot Doc Rsn	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		- - - -	- - - - -
G8428 G8430 G8431 G8432 G8433 G8450	Doctrev Cur Meds by Eng Lin Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng Scr For Dep Not Cpt Doc Rsn	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	- - - - -
G8428 G8430 G8431 G8432 G8433 G8450 G8451	Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rsn Scr For Dep Not Cpt Doc Rsn Beta-Bloc Rx Pt W/Abn Lvef Pt W/Abn Lvef Inelig B-Bloc	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	
G8428 G8430 G8431 G8432 G8433 G8450 G8451	Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng Scr For Dep Not Cpt Doc Rsn Beta-Bloc Rx Pt W/Abn Lvef Pt W/Abn Lvef Inelig B-Bloc	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
G8428 G8430 G8431 G8432 G8433 G8450 G8451 G8452 G8465	Cur Meds Not Document Doc Med Rsn No Medrec Pos Clin Depres Scrn F/U Doc Dep Scr Not Doc Rng Scr For Dep Not Cpt Doc Rsn Beta-Bloc Rx Pt W/Abn Lvef Pt W/Abn Lvef Inelig B-Bloc Pt W/Abn Lvef B-Bloc No Rx	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.		-	-
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G8428 G8430 G8431 G8432 G8433 G8450 G8451 G8452 G8465 G8473 G8474	Cur Meds Not Document Doc Med Rsn No Medrec Pas Clin Depres Scrn F/U Doc Dep Scr Not Doc Rsn Scr For Dep Not Cpt Doc Rsn Beta-Bloc Rx Pt W/Abn Lvef Pt W/Abn Lvef Inelig B-Bloc Pt W/Abn Lvef B-Bloc No Rx High Risk Recurrence Pro Ca Ace/Arb Thxpy Rx?D Ace/Arb Not Rx'D, Doc Reas	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
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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		
G9063	Onc Dx Nsclc Stgi No Progres	review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
		review	_	_
G9064	Onc Dx Nsclc Stg2 No Progres	review.	-	_
G9065	Onc Dx Nsclc Stg3A No Progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. – – –	-	_
G9066	Onc Dx Nsclc Stg3B-4 Metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_
G9067	Onc Dx Nsclc Dx Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_
G9068	Onc Dx Sclc/Nsclc Limited	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
G9069	Onc Dx Scic/Nscic Ext At Dx	review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
		review. — Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9070	Onc Dx Sclc/Nsclc Ext Unknwn	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	_	_
G9075	Onc Dx Brst Metastic/ Recur	review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
		review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
G9077	Onc Dx Prostate T1No Progres	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9078	Onc Dx Prostate T2No Progres	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	_	-
G9084	Onc Dx Colon T1-3 N1-2 No Pr	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9085	Onc Dx Colon T4 N0 W/O Prog	review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9086	Onc Dx Colon T1-4 No Dx Prog	review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9087	Onc Dx Colon Metas Evid Dx	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	_	_
G9091	Onc Dx Rectal T3 N0 No Prog	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		
G9092		review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_
	Onc Dx Rectal T1-3 N1-2Noprg	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_
G9093	Onc Dx Rectal T4 N M0 No Prg			
		review.		-
G9094	Onc Dx Rectal M1 W/Mets Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9094 G9095	Onc Dx Rectal M1 W/Mets Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_
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G9095 G9096	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	- - -
G9095 G9096 G9097	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog Onc Dx Esophageal T4 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review	-	-
G9095 G9096 G9097 G9098	Onc Dx Rectal Extent Unknwn Onc Dx Esophage T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098 G9099	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog Onc Dx Esophageal T4 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098	Onc Dx Rectal Extent Unknwn Onc Dx Esophage T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098 G9099	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur Onc Dx Esophageal Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098 G9099	Onc Dx Rectal Extent Unknwn Onc Dx Esophage T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur Onc Dx Esophageal Unknown Onc Dx Gastric No Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098 G9099	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur Onc Dx Esophageal Unknown Onc Dx Gastric No Recurrence Onc Dx Gastric P R1-R2 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
G9095 G9096 G9097 G9098 G9099 G9100 G9101 G9102 G9103	Onc Dx Rectal Extent Unknwn Onc Dx Esophag T1-T3 Noprog Onc Dx Esophageal T4 No Prog Onc Dx Esophageal Mets Recur Onc Dx Esophageal Unknown Onc Dx Gastric No Recurrence Onc Dx Gastric P R1-R2Noprog Onc Dx Gastric Unresectable Onc Dx Gastric Recurrent	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-
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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	_	_	_
G9134	Onc Nhistg 1-2 No Relap No	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
G9135		review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u>-</u>		-
	Onc Dx Nhl Stg 3-4 Not Relap	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_	-
G9136	Onc Dx Nhl Trans To Lg Bcell	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	_	_	_
G9140	Frontier Extended Stay Demo	review Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
	Outpatient Intravenous Insulin	review. –	<u>-</u>		
G9147		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.028 Policy (CPCP).	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	_	_	_
G9979	Remote E/M New Pt 20Mins	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			
G9980		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	<u>-</u>	_	-
	Remote E/M New Pt 30 Mins	review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_	-
G9981	Remote E/M New Pt 45Mins	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			
G9986	Remote E/M Est. Pt 40Mins	review. — — — — — — — — — — — — — — — — — — —			
		review. — — — — — — — — — — — — — — — — — — —	<u>-</u>	_	-
G9987	Bpci Advanced In Home Visit	review	-	_	-
H0046	Mental Health Service Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
H0047	Alcohol/Drug Abuse Svc Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
J0121	Inj. Omadacycline 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. #N/A	#N/A	Retired 2019	-
J0122	Inj. Eravacycline 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A	#N/A	Retired 2019	
J0129	Abatacept Injection	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.113	Abatacept		
		Prior Authorization per contract agreement. RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.137	Specialty Medication Administration Site of Care	-	-
J0172	Inj Aducanumab-Avwa 2 Mg	Predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.067	Aducanumab-avwa Enzyme-Replacement Therapy for Lysosomal Storage Disorders	1/1/2022	-
J0180	Agalsidase Beta Injection	Prior Authorization per contract agreement. RX501.096	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.	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	2022-04-01	-
J0220	Alglucosidase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	-	-
J0221	Injection Alglucosidase Alfa	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
	(Lumizyme) 10 Mg	Prior Authorization per contract agreement. RX501.096	Specialty Medication Administration Site of Care	-	-
J0222		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			
J0223	Inj. Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 Prior Authorization per contract agreement. RX501.096 RX501.096 RX501.096 RX501.096 RX501.096	Specialty Medication Administration Site of Care	-	-
	Inj Givosiran 0.5 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.125 Prior Authorization per contract agreement. RX501.096	Specialty Medication Administration Site of Care Givosiran Specialty Medication Administration Site of Care	-	-
J0224		Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.133 predetermination to avoid post-service review.	Givosiran	- - 2021-07-01	-
	Inj Givosiran 0.5 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.125 Prior Authorization per contract agreement. RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	Givosiran Specialty Medication Administration Site of Care	- 2021-07-01	-
J0224	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.125 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #MVA	Givosiran Specialty Medication Administration Site of Care	- 2021-07-01 - Retired 2019	-
J0224 J0256 J0291	Inj. Lumasiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.125 Prior Authorization per contract agreement. RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	Givosiran Specialty Medication Administration Site of Care Lumasiran	-	-
J0224 J0256 J0291 J0490	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg	Prior Authorization per contract agreement. MR Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.125 Prior Authorization per contract agreement. MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Naviewed RX501.116 Prior Authorization per contract agreement.	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS01.199 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RXS01.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS01.116 RXS01.133	Givosiran Specialty Medication Administration Site of Care Lumasiran	-	-
J0224 J0256 J0291 J0490 J0491 J0517	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS01.199 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MF Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS01.116 RXS01.138 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination ber contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RXS01.138 Proferia: Procedure/service reviewed against Medical Policy Criteria. Submit for RXS01.138 Proferia: Procedure/service reviewed against Medical Policy Criteria. Submit for RXS01.138 Proferia: Procedure/service reviewed against Medical Policy Criteria. Submit for RXS01.138 Proferia: Procedure/service reviewed against Medical Policy Criteria. Submit for RXS01.138 Proferia: Procedure/service reviewed against Medical Policy Criteria, may require RXS01.100 RXS01.098	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg	Prior Authorization per contract agreement. MR Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.096 MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.116 Prior Authorization per contract agreement. MR Criteria: Procedure/service reviewed against Medical Policy Criteria, submit for predetermination to avoid post-service review. MR Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.100 Prior Authorization per contract agreement. RX501.093 MR Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.093 RX501.093	Givosiran Specialty Medication Administration Site of Care Lumasiran #N/A Belimumab Specialty Medication Administration Site of Care Anifrodumab-fnia Benralizumab	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0517	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg Inj. Benralizumab 1 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.195 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RX501.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.138 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.138 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.006 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.006 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.008 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0517 J0565	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg Inj. Benralizumab 1 Mg Inj Bezlotoxumab 10 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.195 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RX501.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.100 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.006 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.006 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0517 J0565 J0567	Inj Givosiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg Inj. Benralizumab 1 Mg Inj Betotoxumab 10 Mg Inj. Cerliponase Alfa 1 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.133 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RX501.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.138 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.008 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.009	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0517 J0565 J0567 J0584	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg Inj. Benralizumab 1 Mg Inj Bezlotoxumab 10 Mg Inj. Cerliponase Alfa 1 Mg Injection Burosumab-Twza 1M Abobotulinumtoxina	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.135 productive Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.133 predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for procedetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.138 predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.100 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.093 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.092 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.092 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.093 Prior Authorization per contract agreement. NP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.093 Prior Authorization per contract agreement.	Givosiran Specialty Medication Administration Site of Care Lumasiran #N/A Belimumab Specialty Medication Administration Site of Care Anifrodumab-fnia Benralizumab Specialty Medication Administration Site of Care Bezlotxumab Cerliponase alfa Burosumab-tvza Specialty Medication Administration Site of Care	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0565 J0567 J0584 J0586	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj. Benralizumab 1 Mg Inj. Benralizumab 1 Mg Inj. Cerliponase Alfa 1 Mg Injection Burosumab-Twza 1M Abobotulinumtoxina Inj Rimabotulinumtoxinb	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.139 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for procedure/service reviewed against Medical Policy Criteria, may require RX501.138 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.092 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.093 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	-
J0224 J0256 J0291 J0490 J0491 J0517 J0565 J0567 J0584 J0586 J0587	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj. Benralizumab 1 Mg Inj. Benralizumab 1 Mg Inj. Beriotoxumab 10 Mg Inj. Cerliponase Alfa 1 Mg Injection Burosumab-Twza 1M Abobotulinumtoxina Inj Rimabotulinumtoxinb	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.133 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unilsted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RX501.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.098 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.099 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.099 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.099 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.099 Prior Authorization per contract agreement. ME Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 MP Criteria: Procedure/serv	Givosiran Specialty Medication Administration Site of Care Lumasiran	- Retired 2019 - 2022-04-01	
J0224 J0256 J0291 J0490 J0491 J0565 J0567 J0584 J0586	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1 Mg Inj Benralizumab 1 Mg Inj Berlotoxumab 10 Mg Inj. Cerliponase Alfa 1 Mg Injection Burosumab-Twza 1M Abobotulinumtoxina Inj Rimabotulinumtoxina Inj Rimabotulinumtoxinb Injection, Incobotulinumtoxin A, 1	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.135 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require RX501.116 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination ber contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.099 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.092 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.096 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.014 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.019 Prior Authorization per contract agreement. MED201.014 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501	Givosiran Specialty Medication Administration Site of Care Lumasiran	Retired 2019	
J0224 J0256 J0291 J0490 J0491 J0517 J0565 J0567 J0584 J0586 J0587	Inj Givosiran 0.5 Mg Inj. Lumasiran 0.5 Mg Alpha 1 Proteinase Inhibitor Inj. Plazomicin 5 Mg Injection, Belimumab, 10 Mg Inj Anifrolumab-Fnia 1Mg Inj. Benralizumab 1 Mg Inj. Benralizumab 10 Mg Inj. Cerliponase Alfa 1 Mg Injection Burosumab-Twza 1M Abobotulinumtoxina Inj. Rimabotulinumtoxinb Injection, Incobotulinumtoxin A, 1 Unit	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX501.193 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination be avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination be avoid post-service reviewed against Medical Policy Criteria. Submit for professional procedure/service reviewed against Medical Policy Criteria. Submit for professional professiona	Givosiran Specialty Medication Administration Site of Care Lumasiran	- Retired 2019 - 2022-04-01	-
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J1097	Phenylep Ketorolac Opth Soln	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. #N/	,	#N/A	Retired 2019	-
J1290	Ecallantide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5 Prior Authorization per contract agreement. RX5	504.013 501.096	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide Specialty Medication Administration Site of Care	-	-
J1300	Eculizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5	501.066	Eculizumab	_	_
J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5		Specialty Medication Administration Site of Care Edaravone		
J1303	-	Prior Authorization per contract agreement. RX5 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5	501.096 501.107	Specialty Medication Administration Site of Care Ravulizumab-cwvz		
	Inj. Ravulizumab-Cwvz 10 Mg	MB Criteria: Brocedure/convice reviewed against Medical Bolicy Criteria. Submit for	501.096	Specialty Medication Administration Site of Care	-	-
J1305	Inj evinacumab-dgnb 5mg	predetermination to avoid post-service review.	501.136	Evinacumab-dgnb	10/1/2021	-
J1306	Injection inclisiran 1 mg	predetermination to avoid post-service review.	501.142	Inclisiran	7/1/2022	-
J1322	Elosulfase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5 Prior Authorization per contract agreement. RX5	501.067 501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
J1325	Epoprostenol Injection	MR Criteria: Procedure /consider reviewed against Medical Policy Criteria, may require	501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	_
J1426	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX5	501.135	Casimersen	10/1/2021	_
J1427	Vitolarsen, 10 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	501.129	Viltolarsen	5/1/2021	
		predetermination to avoid post-service review.			3/1/2021	-
J1428	Inj Eteplirsen 10 Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	501.084	Eteplirsen	-	-
J1429	Inj Golodirsen 10 Mg	predetermination to avoid post-service review.	501.122	Golodirsen	-	-
J1458	Galsulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5 Prior Authorization per contract agreement. RX5	501.067 501.096	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 RX5	504.003 501.096	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 RX5	504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	7/1/2022	_
J1554	Injection, Immune Globulin	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	4/1/2021	
	(Asceniv), 500Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5		Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	4/1/1011	-
J1555	Inj Cuvitru 100 Mg		501.096	Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
J1556	Inj Imm Glob Bivigam 500Mg		501.096	Specialty Medication Administration Site of Care	-	-
J1557	Injection, Immune Globulin, (Gammaplex), Intravenous, Non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS	504.003 501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	_
HATTE .	Lyophilized (E.G. Liquid), 500 Mg	Prior Authorization per contract agreement. RX5 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5		Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])		
J1558	Inj. Xembify 100 Mg	Prior Authorization per contract agreement. RX5	501.096	Specialty Medication Administration Site of Care	-	-
J1559	Hizentra Injection		501.096	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 RX5 Prior Authorization per contract agreement. RX5	504.003 501.096	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	504.003	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 RX5		Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	_	_
J1568	Octagam Injection	Prior Authorization per contract agreement. RXS MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS	501.096 504.003	Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])		
		Prior Authorization per contract agreement. RX5 MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5	501.096 504.003	Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
J1569	Gammagard Liquid Injection		501.096	Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
J1572	Flebogamma Injection	Prior Authorization per contract agreement. RX5	501.096	Specialty Medication Administration Site of Care	-	-
J1575	Hyqvia 100Mg Immuneglobulin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5 Prior Authorization per contract agreement. RX5	501.096	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.	504.003	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 RX5		Golimumab Specialty Medication Administration Site of Care	_	_
J1632	Inj. Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for RX5	501.096 501.106	Specialty Medication Administration Site of Care Brexanolone for Postpartum Depression		
J1729		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Inj Hydroxyprogst Capoat Nos	contract/clinical review. – MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX5	501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	-	-
J1743	Idursulfase Injection	Prior Authorization per contract agreement. RX5	501.096	Specialty Medication Administration Site of Care	-	-
J1745	Infliximab Not Biosimil 10Mg		E801.028 501.051	Acne Management Infliximab and Associated Biosimilars		_
		Prior Authorization per contract agreement.			_	
14746		Prior Authorization per contract agreement.	501.096	Specialty Medication Administration Site of Care Ibalizumab-uiyk	-	
J1746	Inj. Ibalizumab-Uiyk 10 Mg	Prior Authorization per contract agreement. RXS MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. RXS	501.096 501.099 501.096	Specialty Medication Administration Site of Care Ibalizumab-uyk. Specialty Medication Administration Site of Care	-	-
J1746 J1786	Inj. Ibalizumab-Uiyk 10 Mg Imuglucerase Injection	Prior Authorization per contract agreement. MY Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. RXS Prior Authorization per contract agreement. RXS Prior Authorization per contract agreement. RXS	501.096 501.099 501.096	Specialty Medication Administration Site of Care Ibalizumab-uiyk	- - -	-
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11786	Imuglucerase Injection Inj. Inebilizumab-Cdon 1 Mg Laronidase Injection Inj. Aristada Initio 1 Mg Aripirazole Lauroxil 1 Mg Inj Fensolvi 0.25 Mg Injection Mepolizumab 1 Mg Ziconotide Injection Natalizumab Injection Inj Nusinersen 0.1 Mg Injection Ocrelizumab 1 Mg Injection Pegapatanib Sodium Injection Inj Pasireotide Long Acting Pegapatanib Sodium Injection Injection Pegloticase 1 Mg Plerixafor Injection Ranibizumab Injection Inj susvimo 0.1 mg Injection Reslizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Priori Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Priori Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RXS Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, submit for MED Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, submit for OTHORIC Priorice Procedure/service revi	501.096 501.099 501.099 501.096 501.096 501.096 501.096 501.097 501.096	Specialty Medication Administration Site of Care Enzyme Replacement Therapy for Lyosomal Storage Disorders Specialty Medication Administration Site of Care Enzyme Replacement Therapy for Lyosomal Storage Disorders Specialty Medication Administration Site of Care Inebilizumab-cdon Enzyme Replacement Therapy for Lyosomal Storage Disorders Specialty Medication Administration Site of Care #N/A #N/A #N/A Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists Mepolizumab Specialty Medication Administration Site of Care Ziconotide Natalizumab Specialty Medication Administration Site of Care Nusinersen Orcelizumab Specialty Medication Administration Site of Care Nusinersen Orcelizumab Specialty Medication Administration Site of Care Tezepelumab-ekko Omalizumab Specialty Medication Administration Site of Care Feedumab-ekko Intravited Angiogenesis Inhibitors for Retinal Vascular Disorders Intravited Angiogenesis Inhibitors for Choroidal Vascular Conditions Photodynamic Therapy (POT) for Choroidal Neovascularization (CNV) Regioticase Specialty Medications Administration Site of Care Oncology Medications Intravited Angiogenesis Inhibitors for Retinal Vascular Disorders Intravited Angiogenesis Inhibitors for Retinal Vascular Conditions Photodynamic Therapy (POT) for Choroidal Neovascularization (CNV) Resilizumab Specially Medication Administration Site of Care	- Retired 2019 Retired 2019 2021-07-01	-

J2860	Injection Siltuximab	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. Fremanezumab-Vfrm 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Retired 2019	_
J3032	Inj. Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Eptinezumab-jjmr	_	
J3060	Inj Taliglucerace Alfa 10 U	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Specialty Medication Administration Site of Care Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
		Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096	Specialty Medication Administration Site of Care		-
J3111	Inj. Romosozumab-Aqqg 1 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	Retired 2019	_
J3121	Inj Testostero Enanthate 1Mg	Prior Authorization per contract agreement.	RX501.076	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	RX501.096	Specialty Medication Administration Site of Care	_	_
J3262	Tocilizumab Injection	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Tildrakizumab-asmn Specialty Medication Administration Site of Care		
J3285	Treprostinil Injection	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.115	Tocilizumab Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension		
	<u> </u>	Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	NA301.030	Advanced Therapies for Pharmacologic Treatment of Pulmonary Typertension	_	-
J3301	Triamcinolone Acet Inj Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	-	<u>-</u>	-	5/4/2021
J3315	Triptorelin Pamoate	Prior Authorization per contract agreement.	KX5U2.U61	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	RX501.096	Specialty Medication Administration Site of Care Vedolizumab	=	_
J3385	Velaglucerase Alfa	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
J3396	Verteporfin Injection	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096 OTH903.015	Specialty Medication Administration Site of Care Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		6/30/2022
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	0/ 30/ 5055
J3397	Inj. Vestronidase Alfa-Vjbk	Prior Authorization per contract agreement.	RX501.096	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.	IX301.098	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 Abeparvovec-xioi	-	-
			MED206.001 RX501.063			
			SUR716.001 RX501.105			
			RX501.087			
			RX501.040 RX501.099			
			OTH903.027 OTH903.020			
J3490	Drugs Unclassified Injection		RX504.015		_	_
		contract/clinical review. May require PA per contract agreement.	RX501.080 SUR706.001			
			RX501.086 RX501.085			
			RX501.104			
			RX502.030 MED206.006			
			RX501.110 MED201.014			
J3520	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PV501 040			
33320						
		predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	THE801.008	Chelation Therapy	-	-
J3570	Laetrile Amygdalin Vit B17			Chelation Therapy -	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	RX501.073	Chelation Therapy -	_	-
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	RX501.073 RX501.063 RX501.087 RX501.099	Chelation Therapy	-	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	RX501.073 RX501.063 RX501.087		-	-
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.073 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.080	Chelation Therapy	-	-
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.073 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080	Chelation Therapy	-	-
J3570	Laetrile Amygdalin Vit B17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.073 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.085 RX501.104		-	-
J3570 J3590	Laetrile Amygdalin Vit B17 Unclassified Biologics	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 RX501.063 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.085 RX501.104 RX501.110	Chelation Therapy - - - Human Fibringen Concentrate (RiaSTAP and Fibryga)	-	-
J3570 J3590 J3591 J7177	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract greement. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.073 RX501.063 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.085 RX501.104 RX501.110	-	-	-
J3570 J3590 J3591	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedury/service not specifically defined or classified, may be subject to contract procedure service to specifically defined or classified, may be subject to	RX501.073 RX501.063 RX501.067 RX501.099 RX501.091 RX501.080 RX501.080 RX501.104 RX501.110	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J3590 J3591 J7177 J7178 J7192	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service notract agreement. Unlisted: Procedure/service notract agreement. Unlisted: Procedure/service notract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.073 RX501.063 RX501.067 RX501.099 RX501.091 RX501.080 RX501.080 RX501.104 RX501.110	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J3590 J3591 J7177 J7178 J7192	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Ix Recombinant Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.073 RX501.063 RX501.067 RX501.099 RX501.091 RX501.080 RX501.080 RX501.104 RX501.110	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J3590 J3591 J7177 J7178 J7192 J7195	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Ix Recombinant Nos Hemophilia Clot Factor Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Wh Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.073 RX501.063 RX501.067 RX501.087 RX501.099 RX501.080 RX501.080 RX501.104 RX501.104 RX501.172 RX501.072	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J3590 J3591 J7177 J7178 J7192 J7195 J7309	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Vix Recombinant Nos Hemophilia Clot Factor Noc Methyl Aminolevulinate Top	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.073 RX501.063 RX501.067 RX501.087 RX501.099 RX501.080 RX501.080 RX501.104 RX501.110	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J3570 J3591 J7177 J7178 J7192 J7199 J7309	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Ix Recombinant Nos Hemophilia Clot Factor Noc Methyl Aminolevulinate Top Inj. Yutiq 0.01 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. MF Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MF Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Prior Authorization per contract agreement defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MF Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MF Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MF Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 RX501.063 RX501.067 RX501.087 RX501.099 RX501.080 RX501.010 RX501.010 RX501.072 RX501.072	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	- - - - - - - - - - - - -
J3590 J3591 J7177 J7178 J7192 J7199 J7309 J7314 J7316	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Ix Recombinant Nos Hemophilla Clot Factor Noc Methyl Aminolevulinate Top Inj. Yutiq 0.01 Mg Inj Ocriplasmin 0.125 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 RX501.063 RX501.063 RX501.087 RX501.099 RX501.051 RX501.080 RX501.104 RX501.110	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	- - - - - - - - - - - -
J3590 J3591 J7177 J7178 J7192 J7199 J7309 J7314 J7316	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Ix Recombinant Nos Hemophilia Clot Factor Noc Methyl Aminolevulinate Top Inj. Yutiq 0.01 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.073 RX501.063 RX501.067 RX501.087 RX501.099 RX501.080 RX501.080 RX501.010 RX501.072 RX501.072	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)		- - - - - - - - - - - - - -
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35570 35590	Laetrile Amygdalin Vit B17 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos Factor Viii Recombinant Nos Hemophilia Clot Factor Noc Methyl Aminolevulinate Top Inj. Yutiq 0.01 Mg Inj Ocriplasmin 0.125 Mg Carbidopa Levodopa Ent 100Ml Inj Bimatoprost Itc Imp1Mcg Mometasone Furoate Sinus Imp Mometasone Sinus Sinuva Immunosuppressive Drug Noc Acetylcysteine Comp Unit Levalbuterol Comp Con Albuterol Comp Con Levalbuterol Comp Con Levalbuterol Comp Unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe	RX501.073 RX501.063 RX501.063 RX501.087 RX501.087 RX501.087 RX501.087 RX501.087 RX501.087 RX501.087 RX501.087 RX501.087 RX501.072	- Human Fibrinogen Concentrate (RiaSTAP and Fibryga) Human Fibrinogen Concentrate (RiaSTAP and Fibryga)		- - 6/30/2022

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	RX501.063	Compounded Drug Products	_	-
J7628	Bitolterol Mesylate Comp Con	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7629	Bitolterol Mesylate Comp Unt	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	BVE01 052	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			_	-
J7632	Cromolyn Sodium Comp Unit	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	RX501.063	Compounded Drug Products	_	_
J7636	Atropine Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products		_
J7637	Dexamethasone Comp Con	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
J7638	Dexamethasone Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7640	Formoterol Comp Unit	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	RX501.063	Compounded Drug Products	_	_
J7643	Glycopyrrolate Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
	Ipratropium Bromide Comp	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
J7645	ipracropium Bromide Comp	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Compounded Drug Products	-	-
J7647	Isoetharine Comp Con	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7650	Isoetharine Comp Unit	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	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7667	Metaproterenol Comp Con	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
J7670	Metaproterenol Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.063	Compounded Drug Products	-	-
J7676	Pentamidine Comp Unit Dose	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7680	Terbutaline Sulf Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7681	Terbutaline Sulf Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	_
J7683	Triamcinolone Comp Con	FULLY Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products	_	_
J7684	Triamcinolone Comp Unit	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	RX501.063	Compounded Drug Products		
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
J7685	Tobramycin Comp Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.063	Compounded Drug Products	-	-
J7699	Inhalation Solution For Dme	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	_		_	
J8597	Antiemetic Drug Oral Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
18999	Oral Prescription Drug Chemo	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
J9020	Asparaginase Nos	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	-	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	RX502.061	Oncology Medications		12/31/2021
J9035	Bevacizumab Injection	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	OTH903 027	Untwitteal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions		12/31/2021
J9037	Injection, Belantamab Mafodontin-	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Proceedings of the Contract o	OTH903.015 #N/A	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) #N/A	Moved to PA list	_
19039	Blmg, 0.5Mg Injection Blinatumomab	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		#N/A	Moved to PA list	
	·	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#IV/A		MOVED TO PA IIST	-
J9043	Injection Cabazitaxel 1 Mg	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.	#IV/A	#N/A	-	10/10/2021
J9057	Inj. Copanlisib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	Moved to PA list	_
J9118	Inj. Calaspargase Pegol-Mknl	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Retired 2019	
J9119		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A		
	Inj. Cemiplimab-Rwlc 1 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			Moved to PA list	
J9144	Daratumumab Hyaluronidase	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	Moved to PA list	10/10/2021
J9145	Injection Daratumumab 10 Mg	Prior Authorization per contract agreement.		#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.		Oncology Medications	Moved to PA list	12/31/2021
J9173		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.		#N/A	-	10/10/2021
J9176	Injection Elotuzumab 1Mg	$\label{eq:MPCriteria:Procedure/service} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require}$	#N/A	#N/A	_	10/10/2021
J9177	Inj Enfort Vedo-Ejfv 0.25Mg	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	10/10/2021
J9203		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	Moved to PA list	
		Prior Authorization per contract agreement. MR Criteria: Procedure (convice reviewed against Medical Policy Criteria: Submit for	*			40/40/2024
J9204	inj Mogamulizumab-KpKC 1 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	Moved to PA list	10/10/2021
J9205		Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
J9210	inj. Emapaiumab-Lzsg 1 Mg	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		MD Critoria: Procedure/consice reviewed against Medical Policy Critoria, Submit for	#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	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9226	<u> </u>	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	Moved to PA list	
	Supprelin La Implant	Prior Authorization per contract agreement. MP Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for				12/31/2021
J9227	inj. isatuximab-irrc 10 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	Moved to PA list	10/10/2021
J9228	Injection Ipilimumab 1 Mg	Prior Authorization per contract agreement.		#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	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		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	10/10/2021
J9271	Ini Pembrolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A		10/10/2021
J9281	<u> </u>	Prior Authorization per contract agreement.	#N/A	#N/A	Moved to PA list	10/10/2021
		predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	#14/A	miyA		10/10/2021
J9285	iiij Olaratuillab 10 Mg	review.	-	-	5/15/2021	-
J9295	injection Necitalianian 1 Mg	Brian Authorization per contract agreement	RA302.001	Oncology Medications	-	12/31/2021
J9299		MP Criteria, Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.		#N/A	-	10/10/2021
J9301		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.		#N/A	-	10/10/2021
J9306	Injection Pertuzumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A	_	10/10/2021
J9308	Injection Ramucirumah	Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	#N/A	#N/A		10/10/2021
J9309	•	Prior Authorization per contract agreement. MP Criteria: Procedure (service reviewed against Medical Policy Criteria, Submit for	#N/A		Admired to DA liet	
	inj Polatuzumab Vedotin IMg	predetermination to avoid post-service review.	<u>'</u>	#N/A	Moved to PA list	42/24/222
J9311	inj kituximab Tiyaluromuase	Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9312		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,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	10/10/2021
		predetermination to avoid post-service review.			Moved to 174 list	10/10/2021
J9317	Sacituzulliab Govitecali-Hziy	predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9317 J9325	Ini Talimogene Lahernarenyec	predetermination to avoid post-service review. MR Criteria: Procedure (consist engineer against Medical Policy Criteria: may require	#N/A RX502.061	#N/A Oncology Medications	Moved to PA list	10/10/2021 12/31/2021
	Inj Talimogene Laherparepvec	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authoritation per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			Moved to PA list - 7/1/2022	
J9325	Inj Talimogene Laherparepvec Inj efgartigimod 2mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	
J9325 J9332	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061 RX501.141 #N/A	Oncology Medications Efgartigimod alfa-fcab	- 7/1/2022	
J9325 J9332 J9349 J9352	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg Injection Trabectedin 0.1Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service review. MP Criteria: Procedure/service review. MP Criteria: Procedure/service review. MP Criteria: Procedure/service review.	RX502.061 RX501.141 #N/A	Oncology Medications Efgartigimed alfa-fcab #N/A #N/A	- 7/1/2022 Moved to PA list	12/31/2021
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J9325 J9332 J9339 J9349 J9352 J9354 J9358 J9600 J9999 K0005 K0010 K0011 K0012 K0013 K0014 K0053 K0065 K0108 K0455 K0800 K0801 K0801 K0802 K0806 K0807	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg Injection, Tafasitamab-Cxix, 2Mg Injection Trabectedin 0.1Mg Inj Ado-Trastuzumab Emt 1Mg Inj Fam-Trastu Deru-Nxki 1Mg Porfimer Sodium Injection Chemotherapy Drug Ultralightweight Wheelchair Stnd Wt Frame Power Whichr Stnd Wt Frame Power Whichr Stnd Wt Pwr Whichr W Control Ltwt Portbl Power Whichr Custom Power Whichr Base Elevate Footrest Articulate Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pov Group 1 Std Up To 300Lbs Pov Group 2 Std Up To 300Lbs Pov Group 2 Std Up To 300Lbs Pov Group 2 Hd 301-450 Lbs Pov Group 2 Vhd 451-600 Lbs Pow Group 2 Vhd 451-600 Lbs Power Operated Vehicle Noc	predetermination to avoid post-service review. MP Criteria Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require Procedure/service reviewed against Medical Policy Criteria, may require Procedure/service reviewed against Medical Policy Criteria, may require Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for prede	RX502.061 RX501.141 #IN/A #	Concology Medications Efgartigimod alfa-fcab #N/A #N/A #N/A #N/A #N/A #N/A Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus Wheelchairs and Accessories	7/1/2022 Moved to PA list Moved to PA list	12/31/2021 - - - 10/10/2021
J9325 J9332 J9332 J9334 J9354 J9358 J9600 J9999 K0005 K0010 K0011 K0012 K0013 K0014 K0053 K0065 K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg Injection, Tafasitamab-Cxix, 2Mg Injection Trabectedin 0.1Mg Inj Ado-Trastuzumab Emt 1Mg Inj Fam-Trastu Deru-Nxki 1Mg Porfimer Sodium Injection Chemotherapy Drug Ultralightweight Wheelchair Stnd Wt Frame Power Whichr Stnd Wt Frame Power Whichr Stnd Wt Pwr Whichr W Control Ltwt Portbl Power Whichr Custom Power Whichr Base Other Power Whichr Base Elevate Footrest Articulate Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pov Group 1 Std Up To 300Lbs Pov Group 2 Std Up To 300Lbs Pov Group 2 Hd 301-450 Lbs Pov Group 2 Hd 301-450 Lbs Pov Group 2 Vhd 451-600 Lbs Pov Group 2 Vhd 451-600 Lbs Pow Group 2 Vhd 451-600 Lbs Power Operated Vehicle Noc	predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review against Medical Policy Criteria. Submit for predetermination to avoid post-service review MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Pol	RX502.061 RX501.141 #IN/A #	Efgartigimod alfa-fcab #N/A #N/A #N/A #N/A #N/A #N/A Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus - Wheelchairs and Accessories Wheelchairs and Accessories	7/1/2022 Moved to PA list Moved to PA list	12/31/2021 - - - 10/10/2021
J9325 J9332 J9349 J9352 J9354 J9358 J9600 J9999 K0005 K0010 K0011 K0012 K0013 K0014 K0053 K0108 K0455 K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808 K0812	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg Injection, Tafasitamab-Cxix, 2Mg Injection Trabectedin 0.1Mg Inj Ado-Trastuzumab Emt 1Mg Inj Fam-Trastu Deru-Nxki 1Mg Porfimer Sodium Injection Chemotherapy Drug Ultralightweight Wheelchair Stnd Wt Frame Power Whichr Stnd Wt Frame Power Whichr Custom Power Whichr Custom Power Whichr Base Elevate Footrest Articulate Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pov Group 1 Std Up To 300Lbs Pov Group 2 Hd 301-450 Lbs Pov Group 2 Hd 301-450 Lbs Pov Group 2 Vhd 451-600 Lbs Pov Group 2 Vhd 451-600 Lbs Power Operated Vehicle Noc Pwc Gp 1 Std Port Seat/Back	predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid	RX502.061 RX501.141 #N/A #N/A #N/A #N/A #N/A #N/A THE801.029 RX501.063 RX501.063 RX501.087 RX501.087 RX501.085 RX501.097 DME101.010	Efgartigimod alfa-fcab #N/A #N/A #N/A #N/A #N/A Concologic Applications of Photodynamic Therapy, Including Barrett Esophagus	7/1/2022 Moved to PA list Moved to PA list	12/31/2021 - - - 10/10/2021
J9325 J9332 J9349 J9352 J9354 J9358 J9600 J9999 K0005 K0010 K0011 K0012 K0013 K0014 K0053 K0065 K0108 K0455 K0800 K0801 K0802 K0806 K0807 K0808 K0812 K0813	Inj Talimogene Laherparepvec Inj efgartigimod 2mg Injection, Tafasitamab-Cxix, 2Mg Injection, Tafasitamab-Cxix, 2Mg Injection Trabectedin 0.1Mg Inj Ado-Trastuzumab Emt 1Mg Inj Fam-Trastu Deru-Nski 1Mg Porfimer Sodium Injection Chemotherapy Drug Ultralightweight Wheelchair Stnd Wt Frame Power Whichr Stnd Wt Frame Power Whichr Stnd Wt Portbl Power Whichr Custom Power Whichr Base Other Power Whichr Base Elevate Footrest Articulate Spoke Protectors W/C Component-Accessory Nos Pump Uninterrupted Infusion Pow Group 1 Std Up To 300Lbs Pow Group 1 Hd 301-450 Lbs Pow Group 2 Std Up To 300Lbs Pow Group 2 Std Up To 300Lbs Pow Group 2 Hd 301-450 Lbs Pow Group 2 Std Up To 300Lbs Pow Group 2 Std Up To 300Lbs Power Operated Vehicle Noc Pwc Gp 1 Std Port Seat/Back Pwc Gp 1 Std Port Cap Chair	predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoi	RX502.061 RX501.141 #N/A #N/A #N/A #N/A #N/A #N/A THE801.029 RX501.063 RX501.063 RX501.065 RX501.067 DME101.010	Efgartigimod alfa-fcab #N/A #N/A #N/A #N/A #N/A Concologic Applications of Photodynamic Therapy, Including Barrett Esophagus	7/1/2022 Moved to PA list Moved to PA list	12/31/2021 - - - 10/10/2021

K0816	Pwc Gp 1 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0820	Pwc Gp 2 Std Port Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0821	Pwc Gp 2 Std Port Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0822		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
	Pwc Gp 2 Std Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0823	Pwc Gp 2 Std Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0824	Pwc Gp 2 Hd Seat/Back	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0825	Pwc Gp 2 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0826	Pwc Gp 2 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0827	Pwc Gp Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0828	Pwc Gp 2 Xtra Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0829	Pwc Gp 2 Xtra Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
к0830	Pwc Gp2 Std Seat Elevate S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0831	Pwc Gp2 Std Seat Elevate Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0835	Pwc Gp2 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0836	Pwc Gp2 Std Sing Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0837	Pwc Gp 2 Hd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0838		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
	Pwc Gp 2 Hd Sing Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
к0839	Pwc Gp2 Vhd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0840	Pwc Gp2 Xhd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0841	Pwc Gp2 Std Mult Pow Opt S/B	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0842	Pwc Gp2 Std Mult Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
к0843	Pwc Gp2 Hd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0848	Pwc Gp 3 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	-	_
K0849	Pwc Gp 3 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
к0850	Pwc Gp 3 Hd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0851	Pwc Gp 3 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0852	Pwc Gp 3 Vhd Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0853	Pwc Gp 3 Vhd Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0854	Pwc Gp 3 Xhd Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0855	Pwc Gp 3 Xhd Cap Chair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0856		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories Wheelchairs and Accessories	-	
	Pwc Gp3 Std Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
K0857	Pwc Gp3 Std Sing Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0858	Pwc Gp3 Hd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0859	Pwc Gp3 Hd Sing Pow Opt Cap	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0860	Pwc Gp3 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
K0861	Pwc Gp3 Std Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0862	Pwc Gp3 Hd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
к0863	Pwc Gp3 Vhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0864	Pwc Gp3 Xhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
к0868	Pwc Gp 4 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	_	_
K0869	Pwc Gp 4 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0870	Pwc Gp 4 Hd Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0871	Pwc Gp 4 Vhd Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0877	Pwc Gp4 Std Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories Wheelchairs and Accessories	_	
K0878	Pwc Gp4 Std Sing Pow Opt Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0879		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
	Pwc Gp4 Hd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0880	Pwc Gp4 Vhd Sing Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0884	Pwc Gp4 Std Mult Pow Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0885	Pwc Gp4 Std Mult Pow Opt Cap	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
к0886	Pwc Gp4 Hd Mult Pow S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
К0890	Pwc Gp5 Ped Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0891	Pwc Gp5 Ped Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
к0898	Power Wheelchair Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	-
к0899	Pow Mobil Dev No Dmepdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
K1002	Ces System W/Supplies Access	FIGU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR702 019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation		
12002	223 System Wysuppnes Access	Policy (CPCP).		Just 1943 Summitteen und Fein kallei Lietta Ostiintiiletteit	-	
К1003	Whirlpool Tub Walkin Portabl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
K1004	Lo Freq Us Diathermy Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE803.008	Non-Covered Physical Therapy Services	_	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
K1007	Bil Hkaf Pc S/D Micro Sensor	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME103.008	Powered Exoskeleton for Ambulation in Patients With Lower-Limb Disabilities	3/1/2021	-
K1009	Speech Volume Modulation Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE803.014	Speech-Language Therapy (SLT)	3/1/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
K1018	Ext Up Limb Tremor Stim Wris	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	-
		i oney (erer).				

K1019	Monthly Supp Use With K1018		ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2021-08-15	_
K1020	Non-Invasive Vagus Nerv Stim	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR712.021	Vagus Nerve Stimulation (VNS)	2021-07-01	
K1023	Trans elec nery periph nery	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	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	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	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	1/1/2022	
K1024	Non pneum comp control cal	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	10/1/2021	12/31/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				12/31/2021
K1024	Non pneum comp control cal	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2022	-
K1025	Non pneum compress full arm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	10/1/2021	12/31/2021
K1025	Non pneum compress full arm	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	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	2022-04-01	_
L0999	Add To Spinal Orthosis Nos	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
L1499	Spinal Orthosis Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	_	_
L1834		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME103.002	- Knop Proces	_	6/20/2022
L1834	Ko W/O Joint Rigid Molded To Ko Derot Ant Cruciate Custom	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME103.002	Knee Braces Knee Braces	-	6/30/2022
L1840	Ko W/Adj Jt Rot Cntrl Molded	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	JJ JUJ 2022
L1844 L1846		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME103.002 DME103.002	Knee Braces	-	6/30/2022
	Ko W Adj Flex/Ext Rotat Mold	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		Knee Braces	-	J 3U/ 2U22
L2006	Kaf Sng/Dbl Swg/Stn Mcpr Cus	review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
L2999	Lower Extremity Orthosis Nos	Contract/Clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	-	-	-	-
L3040	Ft Arch Suprt Premold Longit	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
L3050	Foot Arch Supp Premold Metat	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
L3060	Foot Arch Supp Longitud/Meta	Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
L3649	Orthopedic Shoe Modifica Nos	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 Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	-
L6026	Part Hand Myo Exclu Term Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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 Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)		DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6882	Microprocessor Control Uplmb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	6/30/2022
L6920	Wrist Disarticul Switch Ctrl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	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	Prosthesis 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	Prostness 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	DME104.001	Prostness Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L6975	Interscap-Thor Myoelectronic	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Prostness Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L7007	Adult Electric Hand	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	_	6/30/2022
L7008	Pediatric Electric Hand	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	_	_
L7009	Adult Electric Hook	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	_	
L7040	Prehensile Actuator	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	_
L7045	Pediatric Electric Hook	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	_
L7170	Electronic Elbow Hosmer Swit	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	_
L7180	Electronic Elbow Sequential	predetermination to avoid post-service review against Medical Policy Criteria. Submit for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	-
L7181	Electronic Elbo Simultaneous	predetermination to avoid post-service review.	DME104.001	Prosthesis	-	-
L7185	Electron Elbow Adolescent Sw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components, and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components, and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components, and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Including Myoelectric and Orthotic Components and Other Broothesis Except for Lower-Limb Linguistic Republic Prosthesis Included Prosthesis Except for Lower-Limb Linguistic Republic Prosthesis Included Prosthesis Except for Lower-Limb Linguistic Republic Prosthesis Included	-	_
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	-	-

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Q0507 Q0508 Q0509 Q0510 Q0511 Q0512 Q2026 Q2028 Q2039 Q2041 Q2042 Q2043 Q2052 Q2052	Misc Sup/Acc Ext Vad Misc Sup/Acc Imp Vad Mis Sup/Acc Imp Vad Nopay Med Dispens Fee Immunosupressive Sup Fee Antiem Antica Immuno PX Sup Fee Anti-Can Sub Pres Radiesse Injection Inj Sculptra 0.5Mg Influenza Virus Vaccine Nos Axicabtagene Ciloleucel Car+ Tisagenlecleucel Car-Pos T Sipuleucel-T Minimum Of 50 Million Autologous Gd54+ Cells Activated With Pap-Gn-Cri Including Leukapheresis And All Other Preparatory Procedures Per Infusion Doxorubicin inj 10Mg Ivig Demo Services/Supplies Brexucabtagene Autoleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. SUR716.001 WIR Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for contract/clinical review. May require PA per contract agreement.	Cosmetic and Reconstructive Procedures - Oncology Medications Oncology Medications #N/A		-
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Q0507 Q0508 Q0509 Q0510 Q0511 Q0512 Q2026	Misc Sup/Acc Imp Vad Misc Sup/Acc Imp Vad Mis Sup/Ac Imp Vad Nopay Med Dispens Fee Immunosupressive Sup Fee Antiem Antica Immuno Px Sup Fee Anti-Can Sub Pres Radiesse Injection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			- 4/16/2021
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Q0507 Q0508 Q0509 Q0510 Q0511	Misc Sup/Acc Ext Vad Misc Sup/Acc Imp Vad Mis Sup/Acc Imp Vad Nopay Med Dispens Fee Immunosupressive Sup Fee Antiem Antica Immuno	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. On Contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - -	-	- 4/16/2021 - - - -
Q0507 Q0508 Q0509 Q0510	Misc Sup/Acc Ext Vad Misc Sup/Acc Imp Vad Mis Sup/Ac Imp Vad Nopay Med Dispens Fee Immunosupressive	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - -		- 4/16/2021 - - -
Q0507 Q0508 Q0509	Misc Sup/Acc Ext Vad Misc Sup/Acc Imp Vad Mis Sup/Ac Imp Vad Nopay Med	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. — Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. — — — — — — — — — — — — — — — — — — —	- - - -		- 4/16/2021 - -
Q0507 Q0508	Misc Sup/Acc Ext Vad Misc Sup/Acc Imp Vad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	- - - -	-	- 4/16/2021 - -
Q0507	Misc Sup/Acc Ext Vad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. - Unlisted: Procedure/service not specifically defined or classified, may be subject to	- - -	-	4/16/2021
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review Unlisted: Procedure/service not specifically defined or classified, may be subject to	- -	-	4/16/2021
Q0239	Bamlanivimab-Xxxx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	4/16/2021
		Hallata di Barra di antigra da cara da cara de Caralla	-	-	-
P9099	Blood Component/Product Noc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			
P9020	Plaelet Rich Plasma Unit	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). RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
	Hair Analysis	review. – MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for PSY301.014	- Autism Spectrum Disorders (ASD)	_	_
	Cellular Therapy	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	Prosthesis	_	_
	Ewhf S/D Uprt Micro Sensor	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for DMF104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb		
L8701	Ewh S/D Uprt Micro Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L8699	Prosthetic Implant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_
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
L8693	Aud Osseo Dev Abutment	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	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 SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
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	-	_
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	_	-
L8628	Cid Ext Controller Repl	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	Cochlear Implant	-	-
L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	Cochlear Implant	-	-
L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require SUR714.004	Cochlear Implant	-	-
L8623	Lith Ion Batt Cid Non-EarlvI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	Cochlear Implant	-	_
L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	Cochlear Implant	-	_
L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require 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.	Cochlear Implant	-	-
L8618	Coch Implant Tran Cable Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require 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.	Cochlear Implant	-	-
L8616	Coch Implant Microphone Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require 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.	Cochlear Implant	-	-
L8614	Cochlear Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	Cochlear Implant	-	_
L8612	Aqueous Shunt Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Aqueous Shunts and Stents for Glaucoma	-	_
L8608	Arg li Ext Com/Sup/Acc Misc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR713.026 Policy (CPCP).	Retinal Prosthesis	-	-
L8606	Synthetic Implnt Urinary 1MI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR710.008 predetermination to avoid post-service review. SUR710.022 EUI: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	-	-
L8605	Inj Bulking Agent Anal Canal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	-	-
L8604	Dextranomer/Hyaluronic Acid	contract/Clinical review	- Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	-	-
L8499	Unlisted Misc Prosthetic Ser	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	_
L8048	Unspec Maxillofacial Prosth	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	_	=
L8039	Breast Prosthesis Nos	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	_	_
L7499	Upper Extremity Prosthes Nos	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/Cifinical review.	Prosthesis -	_	_
L7366	Battery Chrgr 12 Volt Utah/E	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	_	_
L7364	Twelve Volt Battery Utah/Equ	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. DME104.001	Prostnesis 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	Prostness Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	6/30/2022
17257	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	_	_
L7191	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	_	_

		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
Q4051	Splint Supplies Misc	Contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	-	-	-	-
Q4082	Drug/Bio Noc Part B Drug Cap	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	MR Criteria: Procedure/convice reviewed against Medical Policy Criteria, Submit for	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	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4104	Integra Bmwd	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704 012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			3/13/1011	-
Q4105	Integra Drt Or Omnigraft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4106	Dermagraft	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4107	Graftjacket	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	_
Q4108	Integra Matrix	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4110	Primatrix	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	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4118	Matristem Micromatrix	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4121	Theraskin	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4122	Dermacell Awm Porous Sq Cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/15/2021	
Q4122	Dermacell Awm Porous Sq Cm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/13/2021	3/31/2021
		predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			_	
Q4122	Dermacell Awm Porous Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	10/14/2021
Q4123		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4125	Arthroflex Per Square Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4126	Memoderm/Derma/Tranz/Integup	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	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4136	Ezderm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4137	Amnioexcel Biodexcel 1Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4138	Biodfence Dryflex 1Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4139	Amnio Or Biodmatrix Inj 1Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4140	Biodfence 1Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		
Q4141	Alloskin Ac 1 Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
Q4142	Xcm Biologic Tiss Matrix 1Cm	review. Check FILL policy CPCPOR, which is one of our Clinical Payment and Coding				-
Q4142	Xcm Biologic Tiss Matrix 1Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Biognotiagoned Skin and Soft Tirrus Substitute		
Q4143	Repriza 1Cm	Policy (PCP). EUL Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP08, which is one of our Clinical Payment and Coding Policy (PCP). EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012 SUR704.011	Bioengineered Skin and Soft Tissue Substitutes Amniotic Membrane and Amniotic Fluid Bioengineered Skin and Soft Tissue Substitutes		-

Q4147	Architect Ecm Px Fx 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4148	Neox Neox Rt Or Clarix Cord	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4150	Allowrap Ds Or Dry 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4151	Amnioband guardian 1 sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4152	Dermapure 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4153	Dermavest Plurivest Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4154	Biovance 1 square cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	
Q4155	Neoxflo Or Clarixflo 1 Mg	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		Amniotic Membrane and Amniotic Fluid		-
Q4156	Neox 100 Or Clarix 100	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
Q4157	Revitalon 1 Square Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4158	Kerecis Omega3 Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4159	Affinity1 Square Cm	predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	2/1/2022	-
Q4159	Affinity1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	1/31/2022
Q4160	Nushield 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4161	Bio-Connekt Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4162	Wndex Flw Bioskn Flw 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4163	Woundex Bioskin Per Sq Cm	Folicy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4164	Helicoll Per Square Cm	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4165	Keramatrix Kerasorb Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4166	Cytal Per Square Centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4167	Truskin Per Sq Centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4168	Amnioband 1 mg	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	
Q4169	Artacent Wound Per Sq Cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amiliotic Membrane and Amiliotic Fluid	-	_
Q4170	Cygnus Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		
Q4171	Interfyl 1 Mg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		-
Q4173	Palingen Or Palingen Xplus	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
Q4174	Palingen Or Promatrx	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4175	Miroderm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	-
Q4176	Neopatch Or Therion, Per Square Centimeter	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4178	Floweramniopatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4179	Flowerderm Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4180	Revita Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4181	Amnio Wound Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4182	Transcyte Per Sq Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4183	Surgigraft 1 Sq Cm	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4184	Cellesta Or Duo Per Sq Cm	Folicy (EPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4185	Cellesta Flowab Amnion 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4186	Epifix 1 sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	
Q4187	Epicord 1 sq cm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	
Q4187	Amnioarmor 1 Sq Cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Memorane and Amniotic Fluid Amniotic Membrane and Amniotic Fluid		_
Q4189	Artacent Ac 1 Mg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		
	Ů	Policy (CPCP).				

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4190	Artacent Ac 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4191	Restorigin 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4192	Restorigin 1 Cc	Folicy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4193	Coll-E-Derm 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4194	Novachor 1 Sq Cm	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4195	Puraply 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4196	Puraply Am 1 Sq Cm	Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4197	Puraply Xt 1 Sq Cm	Folicy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4198	Genesis Amnio Membrane 1Sqcm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4199	Cygnus Matrix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-15	-
Q4200	Skin Te 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4201	Matrion 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4202	Keroxx (2.5G/Cc) 1Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4203	Derma-Gide 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Pales. (CPCP)	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4204	Xwrap 1 Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Pales. (CPC)	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4205	Membrane Graft Or Wrap Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4206	Fluid Flow Or Fluid Gf 1 Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4208	Novafix Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4209	Surgraft Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4210	Axolotl Graf Dualgraf Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4211	Amnion Bio Or Axobio Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4212	Allogen Per Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4213	Ascent 0.5 Mg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid		_
Q4214	Cellesta Cord Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4215	Axolotl Ambient Cryo 0.1 Mg	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid		_
Q4216	Artacent Cord Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		
Q4217	Woundfix Biowound Plus Xplus	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid		-
Q4218	Surgicord Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid	-	-
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
Q4219 Q4220	Surgigraft Dual Per Sq Cm Bellacell Hd Surederm Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011 SUR704.012	Amniotic Membrane and Amniotic Fluid Bioeneineered Skin and Soft Tissue Substitutes	-	5/14/2021
Q4220	Bellacell Hd Surederm Sq Cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4221	Amniowrap2 Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Amniotic Membrane and Amniotic Fluid	_	_
Q4222	Progenamatrix Per Sq Cm	Policy (CPCP). 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	-	5/14/2021
Q4222	Progenamatrix Per Sq Cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4224	Hhf10-P Per Sq Cm	Folicy (CPCP). EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4225	Amniobind Per Sq Cm	Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	-
Q4227	Amniocore Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4228	Bionextpatch Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	9/30/2021
Q4229	Cogenex Amnio Memb Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	-
Q4230	Cogenex Flow Amnion 0.5 Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Pales. (CPCP)	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4231	Corplex P Per Cc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4232	Corplex Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
		Policy (CPCP).				

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
Q4233	Surfactor /Nudyn Per 0.5 Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4234	Xcellerate Per Sq Cm	Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid		_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
Q4235	Amniorepair Or Altiply Sq Cm	Policy (CPCP).	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 SUR704.011 Policy (CPCP).	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	Amniotic Membrane and Amniotic Fluid	_	_
Q4238	Derm-maxx, per sq cm	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR704.011	Amniotic Membrane and Amniotic Fluid	02.01/2022	6/30/2022
Q4238	Derm-maxx, per sq cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	7/1/2022	
	7,5-1,5-1	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-,-,	-
Q4239	Amnio-Maxx Or Lite Per Sq Cm	Policy (CPCP).	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 SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Q4241	Polycyte Topical Only 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Amniotic Membrane and Amniotic Fluid	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
Q4242	Amniocyte Plus Per 0.5 Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Amniotic Membrane and Amniotic Fluid	-	-
Q4244	Procenta Per 200 Mg		Amniotic Membrane and Amniotic Fluid	-	-
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Amniotic Membrane and Amniotic Fluid	_	_
04245	Contrat Or Post at 1995	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
Q4246	Coretext Or Protext Per Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Amniotic Membrane and Amniotic Fluid	-	-
Q4247	Amniotext Patch Per Sq Cm		Amniotic Membrane and Amniotic Fluid	-	-
Q4248	Dermacyte Amn Mem Allo Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4249	Amniply Per Sq Cm	Policy (PCPC). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	
Q4243	Anniply Fer 3q Cili	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Animode Memorane and Animode Field	3/1/2021	-
Q4250	Amnioamp-Mp Per Sq Cm	Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4251	Vim per square centimeter	predetermination to avoid post-service review.	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 SUR704.011 Policy (CPCP).	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.	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4252	Vendaje per square centimet		Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4253	Zenith amniotic membrane psc	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4253	Zenith amniotic membrane psc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	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 SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4255	Reguard Topical Use Per Sq		Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4256	Mlg Complet Per Sq Cm		Amniotic Membrane and Amniotic Fluid	2022-04-01	_
Q4257	Relese Per Sq Cm	Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	2022-04-01	
Q4237	Relese Per Sq CIII	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Animout wembrane and Animotic Field	2022-04-01	-
Q4258	Enverse Per Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	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	Prior Authorization per contract agreement. RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
Q5104	Injection Renflexis	Prior Authorization per contract agreement. RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
Q5106	Inj Retacrit Non-Esrd Use	Prior Authorization per contract agreement.	Erythropoiesis-Stimulating Agents (ESAs)	-	-
Q5107	Inj Mvasi 10 Mg	predetermination to avoid post-service review.	#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 RX501.051	Infliximab and Associated Biosimilars	-	-
Q5115	Inj Truxima 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require RX502.030 Prior Authorization per contract agreement.	Rituximab and Biosimilars for Non-Oncologic Indications	-	-
Q5118	Inj. Zirabev 10 Mg	predetermination to avoid post-service review.	HN/A	Moved to PA list	10/10/2021
Q5119	Inj Ruxience 10 Mg	predetermination to avoid post-service review.	#N/A	Moved to PA list	10/10/2021
Q5124	Inj. Byooviz 0.1 Mg	predetermination to avoid post-service review.	Ranibizumab Injections, Implants and Biosimilars	2022-04-01	-
S0013	Esketamine Nasal Spray	predetermination to avoid post-service review.	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	Prior Authorization per contract agreement.	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
S0189	Testosterone Pellet 75 Mg	Prior Authorization per contract agreement	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	-	-
50197	Prenatal Vitamins 30 Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- гозолого перавення пинариех	-	-
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.	-	-	-
50622	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	_	_
50810	Photorefractive Keratectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	2			
S1001	Deluxe Item	review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Deluxe Item	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
S1002	Custom Item	contract/clinical review.	-	-	-	-
S1040	Cranial Remolding Orthosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME103.007	Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses	_	6/30/2022
S1091	Stent Non-Coronary Propel	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.001	Nasal and Sinus Surgery	5/15/2021	
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			3/13/1011	
S2083	Adjustment Gastric Band	predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	-
S2112	Knee Arthroscp Harv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	2022-05-01	-
52117	Authorization California	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	CURTOF 027	Political and Anthonoral (PPA)		
32117	Arthroereisis Subtalar	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	THE802.003	Lipid Apheresis		
		Prior Authorization per contract agreement.				
\$2140	Cord Blood Harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.040 SUR703.040 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.031	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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for General Review February (Cell Transplantation for General Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Fothelia (Dovarian Cancer Hematopoietic Cell Transplantation for Hodgikin Lymphoma (HL) Hematopoietic Cell Transplantation for Hodgikin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Malignant Order Malignant Malignant Malignant Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelogypastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Splatfur one of Cell Tra	-	-
S2142	Cord Blood-Derived Stem-Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.050 SUR703.045 SUR703.037 SUR703.002 SUR703.002 SUR703.003 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.041 SUR703.045 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.036 SUR703.036 SUR703.036 SUR703.036 SUR703.045	Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Resat Cancer Hematopoietic Cell Transplantation for Forest Cancer Hematopoietic Cell Transplantation for Forest Cancer Hematopoietic Cell Transplantation for Crivnoic Myeloid Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Forest Cancer Hematopoietic Cell Transplantation for Forest Cell Transplantation for Myelographia Stronyctomas and Gliomas Hematopoietic Cell Transplantation for Myelographistic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelographistic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plansa Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plansa Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Selman Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Selman Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Selman Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Mellegraphic Macroglobulinemia	-	-
\$2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.035 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 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 Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodefliciency Syndrome (AIDS) Hematopoietic Cell Transplantation for Reast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Committed Syndroid Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Pimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Fireary Systemic Amyloidosis Hematopoietic Cell Transplantation for Fireary Systemic Amyloidosis Hematopoietic Cell Transplantation for Fireary Systemic Amyloidosis	-	-
S2202	Echosclerotherapy	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	SUR714.009	Auditory Brainstem Implant	_	_
52300	Arthroscopy Shoulder Surgi	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).	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 O Robotic Surgical System (List Separately In Addition To Code For	f MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.014	Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery	-	-
\$3600	Primary Procedure) Stat Lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	2			
		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	-	-
53652	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	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	_	_
S4015	Complete Ivf Nos Case Rate	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
S4023	Incompl Donor Egg Case Rate	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
S4025	Donor Serv Ivf Case Rate	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
S4026	Procure Donor Sperm	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	
S4026	· · · · · · · · · · · · · · · · · · ·	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023		-	_
	Store Prev Froz Embryos	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Services for Infertility and Recurrent Fetal Loss	-	-
S4030	Sperm Procure Init Visit	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
S4031	Sperm Procure Subs Visit	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	
S4040	Monit Store Cryo Embryo 30 D	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	_
S4990	Nicotine Patch Legend	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
54991	Nicotine Patch Nonlegend	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	_	_	_	_
S5110	Family Homecare Training 15M	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_		_	
S5111	Family Homecare Train/Sessio	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		-	
55115	Nonfamily Homecare Train/15M	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_		-	
S5115		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-	-
	Nonfamily Hc Train/Session	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
S5120	Chore Services Per 15 Min	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5121	Chore Services Per Diem	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-	-
S5125	Attendant Care Service /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	-	-	-	-
S5126	Attendant Care Service / Diem	review.	-	-	-	-
S5130	Homaker Service Nos Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. $ \\$	_	-	-	_
		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5131	Homemaker Service Nos /Diem	review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
S5135	Adult Companioncare Per 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	_	-	_
S5136	Adult Companioncare Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5140	Adult Foster Care Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
S5141	Adult Foster Care Per Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S5145	Child Fostercare Th Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S5146	Ther Fostercare Child /Month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S5150	Unskilled Respite Care /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
S5151	Unskilled Respitecare / Diem	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5160	Emer Response Sys Instal&Tst	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		_
S5161	Emer Rspns Sys Serv Permonth	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5161 S5162		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
	Emer Rspns System Purchase	review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5165	Home Modifications Per Serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	-	-	-	-
S5170	Homedelivered Prepared Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5175	Laundry Serv Ext Prof /Order	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 Unlisted: Procedure/service not specifically defined or classified, may be subject to				
S8035		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
30033	Magnetic Source Imaging		RAD601.038	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
S8130	Interferential Current Stimulator 2 Channel	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	Folicy (Focedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.041	Interferential Current Stimulation		
	Channel	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to			-	
58189	Trach Supply Noc	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	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	THE803.022	Hippotherapy	-	-
58948	Low-Level Laser Trmt 15 Min	Policy (CPCP). 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				
36330	Pt Of Manip For Manit	review.	-	<u>-</u>	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
S9001	Home Uterine Monitor With Or		DB401.017	Home Uterine Activity Monitoring	_	_
		Policy (CPCP).				
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
S9056	Coma Stimulation Per Diem	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.014	Sensory Stimulation for Coma Patients	-	_
		Policy (CPCP).				
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
S9090	Vertebral Axial Decompressio		THE803.021	Non-Surgical Spinal Decompression Traction Devices	-	_
		Policy (CPCP).				
S9117	Back School Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.024	Back School		
		predetermination to avoid post-service review.				
S9125	9125 Respite Care In The Home P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.	-	-	-	-
59335	Ht Hemodialysis Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	
	·	predetermination to avoid post-service review.				_
59379	Hit Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review.				_
59381	Hit High Risk/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.		<u>-</u>		_
59436	Lamaze Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.		<u>-</u>		-
59437	Childbirth Refresher Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_		_	_
		review.				
59438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_		_	_
		review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
59439	Vbac Class	review.	_		_	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9442	Birthing Class	review.	_		_	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9444	Parenting Class	review.	-	_	_	_
		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
S9445	Pt Education Noc Individ	contract/clinical review.	-		-	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9446	Pt Education Noc Group	review.				
		Unlisted: Procedure/service not specifically defined or classified	-		-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9447	Infant Safety Class	review.	-	-	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9449	Weight Mgmt Class	review.	-	•	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9451	Exercise Class	review.		-	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9454	Stress Mgmt Class	review.		-	-	-