

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

Posted March 2022

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

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes that, based on our medical policy, are:

- Subject to a medical necessity review,
- Candidates for a predetermination,
- Not a benefit for our members,
- Considered experimental, investigational and unproven (EIU), or
- Not on our prior authorization list (with some exceptions based on members' benefit plans)

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

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

Procedure Code Groups	Procedure Code Group Description							
Medical Policy Criteria	Procedures/services reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.							
(MP Criteria)	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.							
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.							
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy 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	Code Group & Description	Medical	Medical Policy Title	Effective	Ending
Couc	Description	code Group & Description	Policy No.	incured to they true	Date	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.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11921	Correct Skn Color 6.1- 20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11922	Correct Skin Color Ea 20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive Breast Surgery	-	-
11950	Tx Contour Defects 1 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11951	Tx Contour Defects 1.1-5.0Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11952	Tx Contour Defects 5.1- 10Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	-
11954	Tx Contour Defects >10.0 Cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management	-	_
11960	Insert Tissue Expander(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	_
11970	Rplcmt Tiss Xpndr Perm Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.001 SUR716.011	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures Reconstructive Breast 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	-

	Grfg Autol Fat Lipo 50	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUD716 021	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast		
15771	Cc/<	predetermination to avoid post-service review.	SUR716.011	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		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cosmetic and Reconstructive Procedures		
45776	Grfts Hair Trnspl >15 Punch	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001			
15776	Grafts	predetermination to avoid post-service review.	THE801.028	Cosmetic and Reconstructive Procedures	-	-
15780	Dermabrasion Total Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Acne Management Cosmetic and Reconstructive Procedures		
13780	Dermadrasion Total 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	-	-
			THE801.030	Acne Management		
15781	Dermabrasion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cosmetic and Reconstructive Procedures	_	_
	Segmental 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		
			THE801.028	Acne Management		
15782	Dermabrasion Other Than Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR715.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
			THE801.030	Nonpharmacologic Treatment of Rosacea		
	Dermabrasion Suprfl Any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
15783	Site	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
			THE801.030 THE801.028	Nonpharmacologic Treatment of Rosacea Acne Management		
15786	Abrasion Lesion Single	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
			SUR717.001 THE801.028	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Acne Management		
15787	Abrasion Lesions 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	_	_
		,	SUR717.001 THE801.028	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Acne Management		
15788	Chemical Peel Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.018	Chemical Peels		
	Epiderm	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
			THE801.028	Acne Management		
15789	Chemical Peel Face Dermal	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	_	_
	Dermai	predetermination to droid post service review.	THE801.030	Nonpharmacologic Treatment of Rosacea		
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028	Acne Management Chemical Peels		
15792	Chemical Peel Nonfacial	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
			THE801.030 THE801.028	Nonpharmacologic Treatment of Rosacea Acne Management		
15793	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Chemical Peels		
13793	Chemical Peel Noniacial	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
15820	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Blepharoplasty, Blepharoptosis and Brow Repair		
13620	Revision of Lower Eyella	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15821	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15822	Revision Of Upper Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
45022	Devision Of House Finalist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, Submit for		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	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
	Removal Of Neck	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR712.031	Surgical Deactivation of Headache Trigger Sites Cosmetic and Reconstructive Procedures		
15825	Wrinkles	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15826	Removal Of Brow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
13020	Wrinkles	require Prior Authorization per contract agreement.	SUR712.031	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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures		
13023	Wrinkles	predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
15830	Exc Skin Abd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
			SUR701.024 SUR716.001	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.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
			SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15833	Excise Excessive Skin Leg	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	_	_
			SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15834	Excise Excessive Skin Hip	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	_	_
			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	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
			SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15836	Excise Excessive Skin Arm	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	_	_
			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	_	_
	,	F	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15838	Excise Excess Skin Fat Pad	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	_	_
		F	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15839	Excise Excess Skin &	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
	Tissue	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	SUR716.001	Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review.	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures	-	-
15876	Suction Lipectomy Head&Neck	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	_	_
			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	_	_
			SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15878	Suction Lipectomy Upr Extrem	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	_	_
			SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15879	Suction Lipectomy Lwr Extrem	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	_	_
15000	Removal Of Pressure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR701.024	Surgery for Lipedema and Lymphedema		
15999	Sore	contract/clinical review.	-	-	-	-

17106	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemanglomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17107	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17108	Destruction Of Skin Lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR704.008 THE801.030	Acne Management Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea	-	-
17340	Cryotherapy Of Skin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	THE801.028	Acne Management	-	-
17360	Skin Peel Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028	Acne Management		
17380	Hair Removal By	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	
1/380	Electrolysis	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
17999	Skin Tissue Procedure	contract/clinical review.	-	-	-	-
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	_	_
19300	Removal Of Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.017	Surgical Treatment of Gynecomastia		
	Tissue	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
19303	Mast Simple Complete	predetermination to avoid post-service review.	SUR716.015	Risk-Reducing (Prophylactic) Mastectomy	-	-
19316	Suspension Of Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001 SUR716.010	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Mastopexy	_	_
		require Prior Authorization per contract agreement.	SUR716.011	Reconstructive Breast Surgery Comments and Reconstructive Procedures		
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
19310	Breast Reduction	require Prior Authorization per contract agreement.	SUR716.011 SUR716.012	Reconstructive Breast Surgery Reduction Mammaplasty	-	-
	Breast Augmentation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
19325	W/Implt	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	-	-
19328	Rmvl Intact Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009	Breast Implant, Removal and/or Insertion		
	Implant Rmvl Ruptured Breast	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery Breast Implant. Removal and/or Insertion	-	-
19330	Implant	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	-	-
19340		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009 SUR717.001	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
	Mast	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	-	-
19342	Insj/Rplcmt Brst Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009 SUR717.001	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
	Sep D	predetermination to avoid post-service review.	SUR716.011	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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
19357	Nipple(S) Tiss Xpndr Plmt Brst	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive Breast Surgery		
	Rcnstj Revj Peri-Implt Capsule	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		neconstructive breast surgery	-	-
19370	Brst	predetermination to avoid post-service review.	SUR716.011	Reconstructive Breast Surgery	-	-
19371	Peri-Implt Capsic Brst Compl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion Reconstructive Breast Surgery	_	_
		,	SUR716.021	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast		
19499	Breast Surgery	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR701.037	Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery		
	Procedure	contract/clinical review.	SUR701.031 SUR716.011	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	-	-
20527	Inj Dupuytren Cord	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Reconstructive Breast Surgery Clostridial Collagenase for Fibroproliferative Disorders		
20327	W/Enzyme	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	KX501.073	Clostridial Collagenase for Floroproliferative 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).		Dry Needling of Trigger Points for Myofascial Pain	-	-
20983	Ablate Bone Tumor(S) Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	-	-
20985	Cptr-Asst Dir Ms Px	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	_	_
		Policy (CPCP).				
20999	Musculoskeletal Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
21073	Mnpj Of Tmj W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016 SUR705.010	Manipulation Under Anesthesia Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
21089	Prepare Face/Oral	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Prosthesis	contract/clinical review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21120	Reconstruction Of Chin	predetermination to avoid post-service review.	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
		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		
21121	Reconstruction Of Chin	predetermination to avoid post-service review.	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
			SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21122	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)		
			SUR716.001	Cosmetic and Reconstructive Procedures		
21123	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)		
21125	Augmentation Lower	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21163	Jaw Bone	require Prior Authorization per contract agreement.	SUR705.030 SUR717.001	Orthognathic Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
21127	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21145		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR706.009 SUR705.030	Sleep Related Breathing Disorders: Surgical Management Orthognathic Surgery		
21145	Lefort I-1 Piece W/ Graft	require Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
21146	Lefort I-2 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-

21147	Lefort I-3/> Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
21150	Lefort Ii Anterior	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
	Intrusion	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			_	_
21151	Lefort Ii W/Bone Grafts	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21154	Lefort Iii W/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	_
21155	Lefort Iii W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	_	_
21159	Lefort Iii W/Fhdw/O	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
21133	Lefort I Lefort Iii W/Fhd W/	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may		Orthoghachic Surgery	-	_
21160	Lefort I	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21188	Reconstruction Of Midface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	_	_
21206	Reconstruct Upper Jaw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.030	Orthognathic Surgery		
21200	Bone Augmentation Of Facial	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			_	_
21208	Bones	require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
21209	Reduction Of Facial Bones	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	_
21248	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
21249	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Cranio/Maxillofacial	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
21299	Surgery	contract/clinical review.	-	-	-	-
21499	Head Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
21685	Hyoid Myotomy &	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
21899	Suspension Neck/Chest Surgery	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
21033	Procedure	contract/clinical review. MD Criteria Precedure / conice reviewed against Medical Belieu Criteria Submit for	-	-	-	-
22505	Manipulation Of Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	-
22586	Prescri Fuse W/ Instr L5-	EIU: Procedure/service 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 038	Axial Lumbosacral Interbody Fusion		
22300	S1	Policy (CPCP).	301712.038	Axial cumoosacia interoody i usion	-	-
22899	Spine Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
22999	Abdomen Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	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	-	-
24200	Manipulate Elbow	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	TUE-000 046			
24300	W/Anesth	predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	-
24999	Upper Arm/Elbow Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
25259	Manipulate Wrist W/Anesthes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	_
25999	Forearm Or Wrist	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Surgery Manipulate Finger	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
26340	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	_		_	
27275	Manipulation Of Hip	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.016	- Mariantalian Under Assaktania		_
2/2/3	Joint Arthrodesis Sacroiliac	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	THE803.016	Manipulation Under Anesthesia	-	-
27279	Joint Joint	require Prior Authorization per contract agreement.	SUR705.033	Sacroiliac Joint Fusion or Stabilization	-	-
27280	Fusion Of Sacroiliac Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.033	Sacroiliac Joint Fusion or Stabilization	_	_
			SUR702.017	Facet Joint and Sacroillac Joint Denervation		
27299	Pelvis/Hip Joint Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement until 04/01/2022.	SUR705.019 SUR705.036	Hip Resurfacing (HR) Surgery for Groin Pain in Athletes	_	_
			SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)		
27412	Autochondrocyte Implant Knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	Moved to PA list	12/31/2021
27599	Leg Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
27702	Reconstruct Ankle Joint	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Total Ankle Replacement (TAR)	-	-
27703	Reconstruction Ankle Joint	predetermination to avoid post-service review.	SUR705.021	Total Ankle Replacement (TAR)	-	-
27860	Fixation Of Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	_
27899	Leg/Ankle Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Procedure Osteochondral Talus	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	_		-	_
28446	Autogrft	require Prior Authorization per contract agreement.	SUR705.020	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	-	-
28890	Hi Enrgy Eswt Plantar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries		
		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		
	Fascia	Policy (CPCP).	SUR705.018	Extracorporeal shock wave merapy for infosculoskeletal indications and soft rissue injuries	-	
28899			SUR705.018	-	-	-
28899 29440	Foot/Toes Surgery Procedure Addition Of Walker To	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-	SUR705.018	-	-	_
29440	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping	Policy (PCPC). 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 preservice review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	- -	-	-	-
29440 29799	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping 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 preservice review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	- - -	- - -	- - -	- - -
29440	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip Arthr0 W/Debridement	Policy (PCPP). 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 preservice 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.	- - - SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	- - - 1/1/2022	- - -
29440 29799	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip Arthr0 W/Debridement Autgrft Implit Knee	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 preservice 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, may	- - SUR705.029 SUR705.020		- - - 1/1/2022	-
29440 29799 29862 29866	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip Arthr0 W/Debridement	Policy (PCPP). 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 preservice 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, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- - SUR705.029 SUR705.020 SUR705.035		-	-
29440 29799 29862	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip ArthrO W/Debridement Autgrft impint Knee W/Scope	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 preservice review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Why 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.	- - SUR705.029 SUR705.020		- - 1/1/2022 - 1/1/2022	- - - -
29440 29799 29862 29866 29868	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hijp Arthr0 W/Debridement Autgrt impint Knee W/Scope Meniscal Trnspl Knee	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 preservice 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, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service review.	- SUR705.029 SUR705.020 SUR705.035 SUR705.034	- Surgical Treatment of Femoroacetabular Impingement (FAI) Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions Meniscal Allografts and Other Meniscal Implants	- 1/1/2022	-
29440 29799 29862 29866	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip ArthrO W/Debridement Autgrft Impint Knee W/Scope Meniscal Trnspl Knee W/Scpe	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 preservice 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, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.	- - SUR705.029 SUR705.020 SUR705.035		-	-
29440 29799 29862 29866 29868	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip Arthro W/Scope Meniscal Trnspl Knee W/Scope Hip Arthro	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 preservice review. Service review. 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. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.	- SUR705.029 SUR705.020 SUR705.035 SUR705.034 SUR705.029		- 1/1/2022 1/1/2022	-
29440 29799 29862 29866 29868	Fascia Foot/Toes Surgery Frocedure Addition Of Walker To Cast Castine/Strapping Procedure Hip Arthr0 W/Debridement Autgrt impint Knee W/Scope Meniscal Trnspl Knee W/Scpe Hip Arthro W/Femoroplasty	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 preservice 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, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022.	- SUR705.029 SUR705.020 SUR705.035 SUR705.034	- Surgical Treatment of Femoroacetabular Impingement (FAI) Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions Meniscal Allografts and Other Meniscal Implants	- 1/1/2022	-
29440 29799 29862 29866 29868 29914	Fascia Foot/Toes Surgery Procedure Addition Of Walker To Cast Casting/Strapping Procedure Hip ArthrO W/Scope Meniscal Trnspl Knee W/Scope Hip Arthro W/Femoroplasty Hip Arthro Acetabuloplasty Hip Arthro W/Labral	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 preservice 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. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service 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.			- 1/1/2022 1/1/2022 1/1/2022	-
29440 29799 29862 29866 29868	Fascia Foot/Toes Surgery Frocedure Addition Of Walker To Cast Casting/Strapping Procedure Hip Arthro W/Debridement Autgrft Impint Knee W/Scope Meniscal Trnspl Knee W/Scope Hip Arthro W/Femoroplasty Hip Arthro Acetabuloplasty	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 preservice 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, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. PA maybe required until 04/01/2021.	- SUR705.029 SUR705.020 SUR705.035 SUR705.034 SUR705.029		- 1/1/2022 1/1/2022	-

		MP Criteria: Procedure/service reviewed against Medical Criteria.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)		
29999	Arthroscopy Of Joint	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR705.041 SUR705.024	Thermal Capsulorrhaphy as a Treatment of Joint Instability Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee	-	-
30400	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	_	_
30410	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	_	_
30420	Reconstruction Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		_
30430	Revision Of Nose	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR706.001 SUR717.001	Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		_
30435	Revision Of Nose	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR706.001 SUR717.001	Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR706.001 SUR717.001	Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
30450	Revision Of Nose	require Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR706.001	Nasal and Sinus Surgery	-	-
30468	Rpr Nsl VIv 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 contract/clinical review. May require PA per contract agreement.	SUR706.001	-	-	-
31299	Sinus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	SUR706.019 SUR706.001	-	-	-
31599	Larynx Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
31647	Bronchial Valve Init	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.015	Bronchial Valves	_	_
31648	Insert Bronchial Valve Remov	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706 015	Bronchial Valves	_	_
	Init Bronchial Valve Remov	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
31649	Addl Bronchial Valve Addl	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bronchial Valves	-	-
31651	Insert Airways Surgical	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		Bronchial Valves	-	-
31899	Procedure	contract/clinical review.	-	-	-	-
32994	Ablate Pulm Tumor Perq Crybl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	$Cryosurgical\ Ablation\ of\ Miscellaneous\ Solid\ Tumors\ Other\ Than\ Liver,\ Prostate,\ or\ Dermatologic\ Tumors\ Dermatologic\ Tumors\ Dermatologic\ Tumors\ Dermatologic\ Dermatol$	-	-
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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure		
33213	Dual Insert Pulse Gen Dual	predetermination to avoid post-service 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	_	_
	Leads L Ventric Pacing Lead	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
33225	Add-On Tcat Insj/Rpl Perm Ldls	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	-	-
33274	Pm			Leadless Cardiac Pacemaker	-	-
33275	Tcat Rmvl Perm Ldls Pm W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Leadless Cardiac Pacemaker	-	-
33285	Insj Subq Car Rhythm Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	_	_
33289	Tcat Impl Wrls P-Art Prs Snr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	_	_
33542	Removal Of Heart Lesion	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.026	Cardiac Restoration and Remodeling Procedures	_	_
	Cardiac Surgery	MP Criteria: Procedure/service reviewed against Medical Criteria.	SUR707.026	Cardiac Restoration and Remodeling Procedures		
33999	Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	SUR701.009 SUR703.027	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	-	-
36299	Vessel Injection Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
36465	Njx Noncmpnd Scirsnt 1 Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
36466	Njx Noncmpnd Sclrsnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
36468	Mlt Vn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
	Njx ScIrsnt Spider Veins Njx ScIrsnt 1 Incmptnt	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
36470	Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
36471	Vn	predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	-	-
36473	Endovenous Mchnchem 1St Vein	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR707.016	Varicose Vein Management	-	-
36474	Endovenous Mchnchem Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Varicose Vein Management	-	-
36475	Endovenous Rf 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Varicose Vein Management	-	-
36476	Endovenous Rf Vein Add On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
36478	Endovenous Laser 1St Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
36479	Endovenous Laser Vein	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	
36482	Endoven Ther Chem	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
	Adhes 1St Endoven Ther Chem	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
36483	Adhes Sbsq Apheresis Immunoads	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may		Varicose Vein Management	-	-
36516	Sicty	require Prior Authorization per contract agreement.	THE802.003	Lipid Apheresis	-	-
36522	Photopheresis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.026	Extracorporeal Photopheresis (ECP)	-	-
37215	Transcath Stent Cca W/Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Extracranial Carotid Angioplasty or Stenting	-	-
37216	Transcath Stent Cca W/O Eps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Extracranial Carotid Angioplasty or Stenting	_	-
37217	Stent Placemt Retro Carotid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Extracranial Carotid Angioplasty or Stenting	_	_
37218	Stent Placemt Ante	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.028	Extracranial Carotid Angioplasty or Stenting	_	_
	Carotid Vasc Embolize/Occlude	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			•	-
37241	venous	predetermination to avoid post-service review.		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	-	-

			RAD601.047	Radioembolization for Primary and Metastatic Tumors of the Liver		
37243	Vasc Embolize/Occlude Organ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015 THE801.022	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions Transcatheter Arterial Chemoembolization (TACE) of the Liver	-	-
37244	Vasc Embolize/Occlude Bleed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.015	Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	-	-
37500	Endoscopy Ligate Perf Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
37501	Vascular Endoscopy Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
37700	Revise Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
37718	Ligate/Strip Short Leg Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.016	Varicose Vein Management	_	_
37722	Ligate/Strip Long Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
37735	Vein Removal Of Leg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	
37760	Veins/Lesion Ligate Leg Veins Radical	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
37761		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
	Ligate Leg Veins Open Stab Phleb Veins Xtr 10-	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	30K/07.010	Varicose Vein Management	-	-
37765		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
37766		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Varicose Vein Management	-	-
37780				Varicose Vein Management	-	-
37785	vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Varicose Vein Management	-	-
37799	Vascular Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
38129	Laparoscope Proc Spleen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
38204	BI Donor Search Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.039 SUR703.031 SUR703.041 SUR703.034 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Revous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Certral Revous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Forthonic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodight Inymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Moleyaphoma (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Moleyaphoma (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Paimary Systemic Amyloldosis Hematopoietic Cell Transplantation for Paimary Systemic Amyloldosis Hematopoietic Cell Transplantation for Paimary Systemic Amyloldosis Hematopoietic Cell Transplantation for Malignant Astrocytomas And Melaporoliferative Neoplasms (Hematopoietic Cell Transplantation for Malignant Astrocytomas And Melaporoliferative Neoplasms (HDS) and Melaporoliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Paimary Systemic Amyloldosis Hematopoietic Cell Transplantation for Paimary Systemic Amyloldosis Hematopoietic Cell Transplantation for Malignant Astrocytomas Marcaloudium Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Paima	-	-
38205	Harvest Allogeneic Stem Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.045 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.034 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 Chronic Myeloid 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 Holdgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Formation of Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Formation of Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for General Cell Transplantation for Primary Systemic Amyloidosis	-	-
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 SUR703.002 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.040 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 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 Cronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chonic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (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 Planda (EID Dycarsias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Planda (EID Dycarsias, Including Multiple Myeloma (ITA) 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 General Cell Tumors	-	-

38207	Cryopreserve Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.041 SUR703.042 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Restartion for Restartion for Entral 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 Chronic Myeloid Leukemia (Lt) and Small Lymphocytic Lymphocytic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Pon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Solid Tumors in Adults Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Miscellanceous Cell Dyensais, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Forman Systemic Amyloidosis Hematopoietic Cell Transplantation for Gell Tumors in Adults Hematopoietic Cell Transplantation for Gell Tumors in Children Hematopoietic Cell Transplantation for Gell 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 SUR703.043 SUR703.043 SUR703.045 SUR703.045 SUR703.036 SUR703.029 SUR703.029 SUR703.029 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 Chronic Lymphocytic 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 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 Pon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Pon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Pon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Solid Tumors in Adults 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 Mon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Mon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Mon-Hodgkin Lymphomas	-	-
38209	Wash Harvest Stem Cells		SUR703.037 SUR703.002 SUR703.003 SUR703.047 SUR703.047 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.033 SUR703.040 SUR703.045 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 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 Croncic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Hymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (AIL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas 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 Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Follar Tumors in Children Hematopoietic Cell Transplantation for Follar Tumors in Children Hematopoietic Cell Transplantation for Follar Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Follar Maldenstrom Macroglobulinemia 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	-	-
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 SUR703.043 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.042 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Orionic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphoma Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	-	-

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 SUR703.043 SUR703.043 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.043 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 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 Chronic Myeloid Leukemia (LLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (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 Polandikin Lymphomas Hematopoietic Cell Transplantation for Polandikin Lymphomas Hematopoietic Cell Transplantation for Polandikin Lymphomas Hematopoietic Cell Transplantation for Solid Tumors in Adults 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 Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Foliandikin Lymphomas Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Foliandikin Lymphomas	-	-
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 SUR703.043 SUR703.045 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.041 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 Autoimmune Diseases Hematopoietic Cell Transplantation for React Gancer Hematopoietic Cell Transplantation for React Gancer 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 Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer 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 Pon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Foliam Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Foliam Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Foliam Cell Transplantation for Waldenstrom Macroglobulinemia	-	-
38213	Platelet Deplete Of Harvest		SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.039 SUR703.034 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 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 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 Cronnic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (AIL) Hematopoietic Cell Transplantation for Hodgkin Lymphoma (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 Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Good Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Good Maldenstrom Macroglobulinemia	-	-
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 SUR703.002 SUR703.043 SUR703.043 SUR703.045 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.041 SUR703.041 SUR703.042 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 Breast Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Centrolic Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Grhonic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellanceus 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 Mon-Hodgkin Lymphoma (Cell Transplantation for Non-Hodgkin Lymphomas) Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	-	-

1	18215	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 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.033 SUR703.040 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.044 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 (StLI) Hematopoietic Cell Transplantation for Centrol Cymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (StLI) Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Palsma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Palsma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Palsma Cell Dyscrasias, Including Multiple Myeloma (Ell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Formal Tumors in Children Hematopoietic Cell Transplantation for General Cell Tumors in Children	-	-
ā	18230	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 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.034 SUR703.034 SUR703.035 SUR703.040 SUR703.042 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 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 for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency 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 Critonic Myeloid Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Fepithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Mailgnant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Mailgnant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Mailgnant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Molegian Lymphoma (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Molegian Lymphoma Hematopoietic Cell Transplantation for Pirama Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pirams Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pirams Cell Dyscrasias, Including Multiple Myeloma (MM) and Hematopoietic Cell Transplantation for Mailors of Mailors of Mailors of Mailors (Cell Transplantation for Pirams Cell Dyscrasias, Including Multiple Myeloma (MM) and Hematopoietic Cell Transplantation for Mailors of M	-	-
	18232	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 SUR703.045 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.039 SUR703.041 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.045 SUR703.046 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 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 Chronic Myeloid 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 Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for For Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for For Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Pinama Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for For Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
147	18240	Transpit Allo Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.041 SUR703.039 SUR703.040 SUR703.040 SUR703.035 SUR703.035 SUR703.045 SUR703.035 SUR703.035 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Choric Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Molignant Astrocytomas and Gilomas 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 Plasma Cell Dyscrasias, Including Multiple Myeloma (Ell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gwaldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gwaldenstrom Macroglobulinemia	-	-

38241	Transpit 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 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.033 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.045 SUR703.050 SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for 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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Medgkin Lymphoma (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 Primary Systemic Amyloidosis	-	-
38242	Transpit Allo Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.034 SUR703.034 SUR703.040 SUR703.040 SUR703.040 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 Eventor Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Eventor Income System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Critoric Lymphocytic Leukemia (LLL) 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 Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Mon-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	-	-
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 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.040 SUR703.042 SUR703.040 SUR703.042 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 Immunodefficiency 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 Cronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Malignant Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	-	-
38308	Incision Of Lymph	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024			
38589	Channels Laparoscope Proc	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	23 01.024	Surgery for Lipedema and Lymphedema	_	_
38999	Lymphatic Blood/Lymph System	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
39499	Procedure Chest Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_		_	_
39599	Diaphragm Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
40799	Procedure Lip Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_		_	_
40899	Mouth Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
41530	Tongue Base Vol Reduction	Contact/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 Policy (CPCP).	SUR701.021 SUR706.009	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver Sleep Related Breathing Disorders: Surgical Management	-	-
41599	Tongue And Mouth Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	-
41820	Excision Gum Each Quadrant	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
41821	Excision Of Gum Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
41822	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
41870	Gum Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
41872	Repair Gum	service review.	-	-	-	-

41874	Repair Tooth Socket	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
41899	Dental Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
42145	Procedure Repair Palate	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUB706 000	Sleep Related Breathing Disorders: Surgical Management		
	Pharynx/Uvula	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		Sieep netated dreaming disorders, surgical Management	-	-
42299	Palate/Uvula Surgery	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	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_		_	_
	Procedure Esoph Optical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
43206	Endomicroscopy	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
43210	Egd Esophagogastrc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)		
	Fndoplsty	predetermination to avoid post-service review.	SUP716 002	Bariatric Surgery	-	-
43236	Uppr Gi Scope W/Submuc Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.019 MED201.016	Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	-
	Egd Optical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	WED201.016	Device Therapies for Gastroesophiagear Remox Disease (GERD)		
43252	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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	_	_
43257	Injxn/Mark Egd W/Thrml Txmnt	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.016	Desire Theoretic for Controlled Parking Disease (CEDD)	_	
	Gerd Laps Esophgl Sphnctr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	WILD201.010	Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	-
43284	Agmntj	predetermination to avoid post-service review.	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)	-	-
43289	Laparoscope Proc Esoph	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	_	_
		contract/clinical review.			_	
43499	Esophagus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	MED201.016 SUR709.033	_	_	_
40505	Removal Of Stomach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
43633	Partial	predetermination to avoid post-service review.		Bariatric Surgery	-	-
43644	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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
	Device Lap Revise Gastr Adj	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
43771	Device			Bariatric Surgery	-	-
43772	Lap Rmvl Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	-	-
43773	Lap Replace Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	_	_
43774	Lap Rmvl Gastr Adj All	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
43775	Parts	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
	Lap Sleeve Gastrectomy	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	-	-
43842	V-Band Gastroplasty			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.		Bariatric Surgery	_	_
43845	Gastroplasty Duodenal Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Bariatric Surgery	_	_
43846	Gastric Bypass For	$\label{eq:MPCriteria} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for \mbox{NPC Criteria: Procedure/service reviewed against Medical Policy Criteria.}$	SUR716.003	Bariatric Surgery		
43847	Obesity Gastric Bypass Incl Small	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Bariatric Surgery	_	_
	1	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
43848	Revision Gastroplasty			Bariatric Surgery	-	-
43886	Revise Gastric Port Open			Bariatric Surgery	_	-
43887	Remove Gastric Port	$\label{eq:MPCriteria} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for \mbox{NPC Criteria: Procedure/service reviewed against Medical Policy Criteria.}$	SUR716.003	Bariatric Surgery	_	_
43888	Open Change Gastric Port	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUB716 002	Bariatric Surgery		
	Open Stomach Surgery	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	JUN7 10.003		_	-
43999	Procedure	contract/clinical review.	-	-	-	-
44238	Laparoscope Proc Intestine	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
44705	Prepare Fecal Microbiota	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.049	Fecal Microbiota Transplantation (FMT)	_	_
44799	Unlisted Px Small	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	
44899	Intestine Bowel Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	-
44979	Laparoscope Proc App	contract/clinical review.	-	-	-	-
45399	Unlisted Procedure Colon	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
45499	Laparoscope Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	-	_	_
45999	Rectum Rectum Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Procedure	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
46707	Repair Anorectal Fist W/Plug	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR709.032	Plugs for Fistula Repair	-	-
46999	Anus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Laparo Ablate Liver	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- CURTOS		-	-
47370	Tumor Rf	predetermination to avoid post-service review.		Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	-
47379	Liver	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
47380	Open Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	_
47382	Percut Ablate Liver Rf	$\label{eq:MPCriteria} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for \mbox{NPC Criteria: Procedure/service reviewed against Medical Policy Criteria.}$		Microwave Tumor Ablation	_	_
47399	Liver Surgery Procedure	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		
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	_
47579	Laparoscope Proc Biliary	contract/clinical review.	-	-	-	-
47999	Bile Tract Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	-	-	-	_
		,				

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.	_		_	_
40650	Laparo Proc Hernia	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
49659	Repair Abdomen Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
49999	Procedure	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	_	_
	Transplantation Of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.007	Kidney Transplant		
50360	Kidney	predetermination to avoid post-service review.	SUR703.008 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				
	Perc Rf Ablate Renal	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.038	Microwave Tumor Ablation	_	_
50592	Tumor Perc Cryo Ablate Renal	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.021	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	-	-
50593	Tum	predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	-	-
50949	Laparoscope Proc Ureter	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
51715	Endoscopic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence		
	Injection/Implant	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
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.	5UK/10.022	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	SUR710.023	Prostatic Urethral Lift	_	_
52442	Cystourethro W/Addl	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUP710 022	Prostatic Urethral Lift		
	Implant Insert Prost Urethral	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
53855	Stent	predetermination to avoid post-service review.	MED201.025	Temporary Prostatic Stent	-	-
53860	Transurethral Rf	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)	_	_
	Treatment	Policy (CPCP).				
53899	Urology Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
54125	Removal Of Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
54200	Treatment Of Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Clostridial Collagenase for Fibroproliferative Disorders		
	Lesion Treatment Of Penis	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030 RX501.073	Sexual Dysfunctions, Assessment and Treatment Clostridial Collagenase for Fibroproliferative Disorders	-	-
54205	Lesion	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	-
54235	Penile Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders Sexual Dysfunctions, Assessment and Treatment	_	_
54400	Insert Semi-Rigid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
54401	Prosthesis Insert Self-Contd	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		
	Prosthesis	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
54405	Pros	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	-
54660	Revision Of Testis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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				
FFFF0	Laparo Proc Spermatic	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
55559	Cord Prostate Saturation	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with	-	-
55706	Sampling	predetermination to avoid post-service review.	SUR717.015	Biopsy	-	-
55880	Abltj Mal Prst8 Tiss Hifu	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer	2/1/2021	_
		predetermination to avoid post-service review.	SUR717.014			
	Genital Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria may		High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer		
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)	-	_
	Procedure Sex Transformation M	require Prior Authorization per contract agreement until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.031 SUR710.019		-	-
55970	Procedure Sex Transformation M To F	require Prior Authorization per contract agreement until 04/01/2022. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.031 SUR710.019 SUR717.001	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Nerve Graft With Radical Prostatectomy Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
	Procedure Sex Transformation M To F	require Prior Authorization per contract agreement until 04/01/2022. 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.	SUR717.001 SUR717.001	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Nerve Graft With Radical Prostatectomy	- - -	- -
55970	Procedure Sex Transformation M To F Sex Transformation F To	require Prior Authorization per contract agreement until 04/01/2022. 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 SUR717.001	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Nerve Graft With Radical Prostatectomy Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	- - -	- - -
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	Survey Dalan Adams Du	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
61650	Evasc Pring Admn Rx Agnt 1St	predetermination to avoid post-service review.	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	-	-
61651	Evasc Pring Admn Rx Agnt Add	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.027	Intracranial Stenting or Angioplasty, including Endovascular Procedures	_	_
61850	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR712.025 SUR712.039	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy	_	_
	Neuroelectrodes	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.009	Auditory Brainstem Implant		
61863	Implant Neuroelectrode	require Prior Authorization per contract agreement.	SUR712.025 SUR712.039	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy	-	-
61864	Implant Neuroelectrde	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.009 SUR712.025	Auditory Brainstem Implant Deep Brain Stimulation (DBS)		
01804	Addl	require Prior Authorization per contract agreement.	SUR712.039	Deep Brain Stimulation (DBS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy	-	-
64561	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	_	_
64581	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	_	_
64640	Injection Treatment Of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.040	Ablation of Peripheral Nerves to Treat Pain	5/15/2021	
	Nerve	predetermination to avoid post-service review.	RX501.019			_
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.	SUR703.003 SUR702.017 RX504.015 SUR712.024 SUR701.031	-	-	-
65760	Revision Of Cornea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
65770	Revise Cornea With	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030	Keratoprosthesis	_	_
65785		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Implantation of Intrastromal Corneal Ring Segments		
	Seg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	301713.031		-	-
66174	Translum Dil Eye Canal			Viscocanalostomy and Canaloplasty	-	-
66175	W/Stnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Viscocanalostomy and Canaloplasty	-	-
66179	Aqueous Shunt Eye W/O Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Aqueous Shunts and Stents for Glaucoma	-	-
66180	Aqueous Shunt Eye W/Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		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	_	_
66999	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
67299		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	_
	Eye Surgery Procedure Unlisted Px Extraocular	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
67399	Musc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
67599	Orbit Surgery Procedure	contract/clinical review.	-		-	-
67900	Repair Brow Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR716.004 SUR712.031	Blepharoplasty, Blepharoptosis and Brow Repair Surgical Deactivation of Headache Trigger Sites	-	-
67901	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67902	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67903	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair		
67904	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	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
67906	Repair Eyelid Defect	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	30K/10.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67908	Repair Eyelid Defect	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	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
69090	Surgery Pierce Earlobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
69300	Revise External Ear	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cosmetic and Reconstructive Procedures		
	Outer Ear Surgery	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	5.001		_	-
69399	Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
69705	Uni	predetermination to avoid post-service review.	SUR706.018	Balloon Dilation of the Eustachian Tube	1/15/2021	-
69706	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 Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
69715	Temple Bne Implnt W/Stimulat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	_
69717	Temple Bone Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_
69718	Revision Revise Temple Bone	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids		
	Implant Middle Ear Surgery	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	2.1.7.1.003		-	-
69799	Procedure	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	-	-	-	-
69930	Implant Cochlear Device	require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
69949	Inner Ear Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
69979	Temporal Bone Surgery	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
76496	Fluoroscopic Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
76497	Ct Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	
76498	Mri 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	-	-	-	-
76499	Radiographic Procedure	contract/clinical review.	-	-	-	-

	Echo Examination	Halistady Drocodure (consists not specifically defined as electified, may be subject to			
76999	Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
77299	Radiation Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to		_	_
77200	Planning External Radiation	contract/clinical review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to			
77399	Dosimetry	contract/clinical review.	-	-	-
77499	Radiation Therapy Management	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
77799	Radium/Radioisotope	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_
79000	Therapy Endocrine Nuclear	Unlisted: Procedure/service not specifically defined or classified, may be subject to			
78099	Procedure	contract/clinical review.	-	-	-
78199	Blood/Lymph Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
78299	Gi Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to		_	_
79200	Musculoskeletal Nuclear	contract/clinical review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to			
78399	Exam	contract/clinical review.	-	-	-
78499	Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
78599	Respiratory Nuclear	Unlisted: Procedure/service not specifically defined or classified, may be subject to		_	_
70000	Exam Nervous System Nuclear	contract/clinical review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to			
78699	Exam	contract/clinical review.	-	-	-
78799	Genitourinary Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_
78999	Nuclear Diagnostic Exam	Unlisted: Procedure/service not specifically defined or classified, may be subject to		_	_
70000	Nuclear Medicine	contract/clinical review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to		_	_
79999	Therapy	contract/clinical review.	-	-	-
80299	Quantitative Assay Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	_	_
81099	Urinalysis Test	Unlisted: Procedure/service not specifically defined or classified, may be subject to			
	Procedure	contract/clinical review.		_	_
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	-	_	_
		Unlisted: Procedure/service not specifically defined or classified, may be subject to			
81599	Unlisted Maaa	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		
	_	Policy (CPCP).		-	_
83006	Growth Stimulation Gene 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MED207.158	Molecular Testing For Chronic Heart Failure and Heart Transplant	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
83695	Assay Of Lipoprotein(A)	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.008 Policy (CPCP).	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
		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 Policy (CPCP).	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	-	-
	Lipoprotein Bld Hr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
83701	Fraction	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.008 Policy (CPCP).	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
	Lipoprotein Bld Quan	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
83704	Part	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.008 Policy (CPCP).	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
	Lipoprtn Dir Meas Sd Ldl	FILL Depending /consists not enimbured by the Plan. Not subject to pre-consists			
83722	Chl	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED207.008 Policy (CPCP).	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
		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 MED207.116 Policy (CPCP).	Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	-	-
	Exhaled Breath	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
83987	Condensate	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED201.024 Policy (CPCP).	Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders	-	-
	Eval Amniotic Fluid	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
84112	Protein	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding OB401.018 Policy (CPCP).	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	-	-
		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 Policy (CPCP).	Measurement of Thromboxane Metabolites in Urine	-	-
84999	Clinical Chemistry Test	Unlisted: Procedure/service not specifically defined or classified, may be subject to			
34333		contract/clinical review. – Unlisted: Procedure/service not specifically defined or classified, may be subject to		-	-
85999	Hematology Procedure	contract/clinical review.	-	-	-
86001	Allorgon Coifi-1	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	Allermy Management		
30001	Allergen Specific Igg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED206.001 Policy (CPCP).	Allergy Management	-	-
05040	Leukocyte Histamine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			
86343	Release	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding MED206.001 Policy (CPCP).	Allergy Management	-	-
86352	Cell Function Assay	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for MFD207 147	Immune Cellular Function Assay to Monitor and Predict Immune Function		
	W/Stim Lymphocyte	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		_	-
86353	Transformation	predetermination to avoid post-service review.	Intracellular Micronutrient Analysis	-	-
86486	Skin Test Nos Antigen	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-
86849	Immunology Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to			
		contract/clinical review. – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_	
86910	Test	service review.	•	-	-
86911	Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-

	86950	Leukacyte Transfusion	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 SUR703.043 SUR703.036 SUR703.039 SUR703.039 SUR703.039 SUR703.039 SUR703.041 SUR703.043 SUR703.043 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 Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymona Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymona (SLL) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymona (SLL) Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Primary Systemic Amyoldoosis Hematopoietic Cell Transplantation for Orlamors in Children Hematopoietic Cell Transplantation for Orlamors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gwaldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-	-
Segment of the segmen	86999	Transfusion Procedure		_	_	_	_
segment of the content of the conten	87505	Nfct Agent Detection Gi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	Gastrointestinal Panels	_	_
1907 1907	87506	ladna-Dna/Rna Probe Tq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207 155			
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Soliton	87507	12-25	predetermination to avoid post-service review.	WIED207.133	Gastrointestinal Panels	-	-
Many	87797	Dir	contract/clinical review.	-	-	-	-
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Agriculture	87799			_	-	_	_
Mode	87899	Agent Nos Assay	Unlisted: Procedure/service not specifically defined or classified, may be subject to				_
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Water Wate	88005	Gross	service review.	-	-	-	-
Section	88007			-	-	-	-
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Mariang Microsopy Mari	88028			-	-	_	_
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Segon Processor	88045		service review.	-	-	-	-
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Contract/clinical review.	88199		contract/clinical review.	-	-	-	-
Figure 1 policy (PCPC) (PCPC) which is one of our Clinical Payment and Coding (PCPC) (PCPC) which is one of our Clinical Payment and Coding (PCPC) (P	88299	Cytogenetic Study	contract/clinical review.	-	-	-	-
Netrop Policy (CPCP) Porcedure Por	88375			MED201.038	Confocal Laser Endomicroscopy (CLE)		
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solved in Nobila Service contract/clinical review. Contract/clinical r	88399		contract/clinical review.	-	-	-	-
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Tiss predetermination to avoid post-service review. 8937 Cyopreservation Ocyte(s) predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Ocyte(s) predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Ocyte(s) predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss predetermination to avoid post-service review. 89346 Storage/Year Ropord Manual Policy Criteria Procedure/Service reviewed against Medical Policy Criteria. Submit for Osea, Services for Infertility and Recurrent Fetal Loss prodetermination to avoid post-service review. 8936 Storage/Year Ropord Manual Policy Criteria Procedure/Service not covered by the Plan. Not subject to predetermination to avoid post-service review. 8938 Unlisted Reprod Med Los Procedure/Service not specifically defined or classified, may be subject to contract/clinical review. 8938 Unlisted Reprod Med Los Procedure/Service reviewed against Medical Policy Criteria, may Post 301.014 Autism Spectrum Disorders (ASD)						-	-
934 Storage/ear Embryols Perdetermination to avoid post-service review. 9840 Storage/ear Embryols Perdetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for Sperm/Semen Predetermination to avoid post-service reviewed against Medical Policy Crite		Tiss	predetermination to avoid post-service review.			-	-
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Storage/Year Reprod producterina. Storage/Year Reprod producterina. Submit for producterina. Sub	89343		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
1 Issue predetermination to avoid post-service review. 89346 Storage/Year Docyte(S) 89398 Libit Procedure/service not specifically defined or classified, may be subject to present the process of the p	89344	Storage/Year Reprod	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
Unlisted Reprod Med Lab Proc courte/clinical review	89346						
Lab Proc contract/clinical review				-	-	-	-
			contract/clinical review.	PSV301 014	- Autism Spertrum Disorders (ASD)	-	-
	90283	Human Ig Iv				-	-

90284	Human Ig Sc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
90378	Rsv Mab Im 50Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	_	_
90399	Immune Globulin	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
90689	Vacc liv4 No Prsrv 0.25Ml Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
90749	Vaccine Toxoid	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
90867		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders		
90868		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	_	_
90869	Deli Tcran Magn Stim	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.015	Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders	-	_
90870	Redetemine Electroconvulsive	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electroconvulsive Therapy	-	-
50870	Therapy	predetermination to avoid post-service review.	PSY301.013 PSY301.018	Biofeedback as a Treatment of Chronic Pain	-	-
90875	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022 PSY301.018 PSY301.017 PSY301.019	Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Uninary Incontinence Biofeedback as a Treatment of Uninary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache	-	-
90876	Psychophysiological Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Uniany Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	-	-
90880	Hypnotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.001	Hypnosis	-	-
90885	Psy Evaluation Of Records	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
90889	Preparation Of Report	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
90899	Psychiatric Service/Therapy	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
90901		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	-	-
90912	Bfb Training 1St 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.017 PSY301.016	Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence	4/1/2021	_
90913	Bfb Training Ea Addl 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence	4/1/2021	_
90999	Dialysis Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	biolections as a frequency of officially incontinence	_	_
91034		contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.005	Esophageal pH Monitoring	_	_
91035	Test G-Esoph Reflx Tst	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.005	Esophageal pH Monitoring		_
91037		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.005	Esophageal pH Monitoring	-	-
91038		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Esophageal pH Monitoring	-	-
	> 1Hr Breath	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			_	_
91065	Hydrogen/Methane Test	Policy (CPCP).	MED207.161	Hydrogen or Methane Breath Testing	-	-
91110	Gi Tract Capsule Endoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.042	Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon	-	-
91111	Esophageal Capsule Endoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	-	-
91112	Gi Wireless Capsule Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Gastrointestinal (GI) Motility Measurement	-	-
91117	Colon Motility 6 Hr Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.017	Gastrointestinal (GI) Motility Measurement	-	-
91132	Electrogastrography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.017	Gastrointestinal (GI) Motility Measurement	-	-
91133	Electrogastrography W/Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Gastrointestinal (GI) Motility Measurement	-	-
91299	Procedure Determine Refractive	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non-Coursed: Procedure (service not service de the blan Not subject to service not se	-		-	-
92015	Determine Refractive State Orthoptic/Planetic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
92065	Orthoptic/Pleoptic	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			-	-
	Training	service review.	-			
92132	Cmptr Ophth Dx Img Ant Segmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.021	Optical Coherence Tomography of the Anterior Eye Segment	-	-
92132 92145	Cmptr Ophth Dx Img Ant Segmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPO). Which is one of our Clinical Payment and Coding Policy (PCPO). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, which is one of our Clinical Payment and Coding Policy (PCPO).		Optical Coherence Tomography of the Anterior Eye Segment Corneal Hysteresis	-	-
	Cmptr Ophth Dx Img Ant Segmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCP08, which is one of our Clinical Payment and Coding Policy (PCP0). EIU: Procedure/service not reimbursed 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.			- - -	- -
92145	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			- - -	- - -
92145 92340	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal	EIU: Procedure/service not reimbursed 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			- - -	- - - -
92145 92340 92341	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal Fit Spectacles Bifocal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPO). Which is one of our Clinical Payment and Coding Policy (PCPO). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPO8, which is one of our Clinical Payment and Coding Policy (PCPO). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-	-
92145 92340 92341 92342	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal Fit Spectacles Bifocal Fit Spectacles Multifocal Fit Spectacles Multifocal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPD), which is one of our Clinical Payment and Coding Policy (PCPD). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCPOS, 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-	-
92145 92340 92341 92342 92354	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal Fit Spectacles Bifocal Fit Spectacles Multifocal Fit Spectacles Single System Fit Spectacles	EIU: Procedure/service not reimbursed 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-	-
92145 92340 92341 92342 92354 92355	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal Fit Spectacles Bifocal Fit Spectacles Multifocal Fit Spectacles Single System Fit Spectacles Compound Lens Repair & Adjust	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPU). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPU). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPU). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.			-	- - - - -
92145 92340 92341 92342 92354 92355 92370	Cmptr Ophth Dx Img Ant Segmt Corneal Hysteresis Deter Fit Spectacles Monofocal Fit Spectacles Bifocal Fit Spectacles Multifocal Fit Spectacles Single System Fit Spectacles Compound Iens Repair & Adjust Spectacles Eye Service Or Procedure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPO). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPO). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPO). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	OTH903.031		- - - - - - - - -	- - - - - - - -

92517		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	5/15/2021	-
92518	Vemp Test I&R Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.047	Vestibular Function Testing	5/15/2021	_
92519		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.047	Vestibular Function Testing	5/15/2021	_
92546	Sinusoidal Rotational	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201 047	Vestibular Function Testing		
92548	lest	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		Dynamic Posturography	-	-
92549		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			-	-
	Mct&Adt Aud Brainstem Implt	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Dynamic Posturography	-	-
92640	Programg	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	SUR714.009	Auditory Brainstem Implant	-	-
92700	Ent Procedure/Service	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-	-	-
93050	Art Pressure Waveform Analys	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.070	Non-Invasive Measurement of Central Blood Pressure (cBP)	-	-
93228	Rev/Report	predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
93229	Supp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
93660		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.048	Tilt Table Testing	-	-
93702	Analysis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.036	Bioimpedance Devices for Detection and Management of Lymphedema	-	_
93740	Temperature Gradient	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	RAD601.014	Thermography	_	_
93797	Cardiac Rehab	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.023	Cardiac Rehabilitation (CR)		
93798	Cardiac Rehab/Monitor	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.023	Cardiac Rehabilitation (CR)	_	_
93799	Cardiovascular Procedure	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
93998	Noninvas Vasc Dx Study	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
94014	Patient Recorded	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.040	Home Spirometry	-	-
94015	Patient Recorded	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).	DME101.040	Home Spirometry	_	_
94016	Review Patient Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	DME101.040	Home Spirometry	_	_
94452		Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
94453	Hast W/Oxygen Titrate	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_		_	_
94799	Pulmonary Service/Procedure	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
95060	Eye Allergy Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	_	_
95065	Nose Allergy Test	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	MED206.001 PSY301.014	Allergy Management Autism Spectrum Disorders (ASD)	_	_
95199	Allergy Immunology	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
95700		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		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	_
95706	Eeg Wo Vid 2-12Hr Intmt 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	_	_
95707	Eeg W/O Vid 2-12Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	_	_
95708	Eeg Wo Vid Ea 12-26Hr 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	_	_
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	Cont	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95711	Veeg 2-12 Hr Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95712	Veeg 2-12 Hr Intmt 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	-	-
95713	Veeg 2-12 Hr Cont Mntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MD Criteria: Procedure/review review against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95714	Unmntr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MD Criteria: Procedure/review review against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95715	Mntr	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	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95716	Mntr	medical role of the control of the c	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95717	W/O Vid	medical role of the control of the c	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95718	W/Veeg	predetermination to avoid post-service review.	MED205.008 MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95719 95720	W/O Vid	predetermination to avoid post-service review.	MED205.008 MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95720	W/Veeg Eeg Phy/Qhp>36<60 Hr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008 MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95721		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 Ambulatory or Video Electroencephalogram (EEG) Monitoring, including Digital Analysis of Electroencephalogram	-	-
95723		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	_	_
95724	W/O Vid Eeg Phy/Qhp>60<84 Hr W/Veeg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-

	Eeg Phy/Qhp>84 Hr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
95725	W/O Vid	predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95726	Eeg Phy/Qhp>84 Hr W/Veeg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95803	Actigraphy Testing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.048	Actigraphy	_	_
OFOOF	Motor &/ Sens Nrve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED205 022	Automated Related Constitute Conduction Testina		
95905	Cndj Test	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033	Automated Point-of-Care Nerve Conduction Testing	-	-
95954	Eeg Monitoring/Giving	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram		
	Drugs	predetermination to avoid post-service review.			-	-
95957	Eeg Digital Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.008	Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram	-	-
95961	Electrode Stimulation Brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Mapping (Quantitative Electroencephalography)	-	_
95962	Electrode Stim Brain Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.011 MED205.009	Intraoperative Neurophysiologic Monitoring (IONM) Topographic Brain Mapping (Quantitative Electroencephalography)	_	_
95965	Meg Spontaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.038 PSY301.014	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD)	-	-
95966	Meg Evoked Single	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.038	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD)	-	-
95967	Meg Evoked Each Addl	predetermination to avoid post-service review.	RAD601.038	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	-
95999	Neurological Procedure	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
96000	Motion Analysis Video/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	_	_
96001	, .	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.009	Gait Analysis		
	Meas	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gait Analysis	-	-
96002	Dynamic Surface Emg	predetermination to avoid post-service review.	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
96003	Dynamic Fine Wire Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	-	-
96004	Phys Review Of Motion Tests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009 MED205.006	Gait Analysis Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
96379	Ther/Prop/Diag Inj/Inf Proc	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_	<u>-</u>	_	_
96549	Chemotherapy	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Unspecified Photochemotherapy	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
96912	With Uv-A	predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
96913	A Or B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
96922	Laser Tx Skin >500 Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 THE801.033	Acne Management Phototherapy for Dermatologic Conditions	-	_
96931	Rcm Celuir Subceluir Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	_	_
96932		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy		
	Skn Rcm Celuir Subceluir Img	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
96933	Skn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	-	-
96934	Skn	predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	-
96935	Skn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	_	_
96935 96936	Skn Rcm Celuir Subceluir Img	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.023 MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	-	-
	Skn Rcm Celuir Subceluir Img Skn Dermatological	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			-	-
96936 96999	Skn Rcm Celuir Subceluir Img Skn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.			-	-
96936 96999 97039	Skn Rcm Celuir Subceluir Img Skn Dermatological Procedure Physical Therapy Treatment	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. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.			- - -	- - -
96936 96999	Skn Rcm Celuir Subceluir Img Skn Dermatological Procedure Physical Therapy Treatment Physical Medicine Procedure	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. 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.			- - - -	- - - -
96936 96999 97039	Skn Rem Celuir Subceluir Img Skn Dermatological Procedure Physical Therapy Treatment Physical Medicine	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. 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			-	- - - -
96936 96999 97039 97139	Skn Rcm Celuir Subceluir Img Skn Dermatological Procedure Physical Therapy Treatment Physical Medicine Procedure Athletic Trn Eval Low	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. 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.				-
96936 96999 97039 97139 97169	Skn Rcm Celulr Subcelulr Img Skn Dermatological Procedure Physical Therapy Treatment Physical Medicine Procedure Athletic Trn Eval Low Cmpix Athletic Trn Eval Mod Cmptx Athletic Trn Eval Hod Athletic Trn Eval High	predetermination to avoid post-service review. MP Criteria: Procedure/service review 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.			-	-
96936 96999 97039 97139 97169 97170	Skn Rcm Celulr Subceluir Img Skn Dermatological Procedure Physical Therapy Treatment Physical Medicine Procedure Athletic Trn Eval Low Cmplx Athletic Trn Eval Mod Cmplx Athletic Trn Eval High Cmplx Omplx Athletic Trn Eval High Cmplx Omplx O	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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.			-	-
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Mathematical Math	99360		service review.	-	-	-	-
March Marc	99429			_	-	_	_
March Marc	99446			-	-	1/1/2021	_
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March Marc	99447	11-20	service review.	-	-	1/1/2021	-
Marie	99448			_	_	1/1/2021	_
Manual							
Second		31/>	service review.	-	-	1/1/2021	-
Second S	99450	Exam	service review.	-	-	-	-
March Marc	99451	5/>	service review.	-	-	1/1/2021	-
March Marc	99452			-	-	1/1/2021	-
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Section Sect	99455	Work Related Disability	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
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Company Comp				-	-	-	-
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March Marc	99600	Home Visit Nos	contract/clinical review.	-	-	-	_
Part	0052U		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	-	_
Section Sect							
Part	0054T			SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	-	-
March Part	0055T	Bone Srgry Cmptr Ct/Mri		SUID 705 022	Computer Assisted Navigation for Orthopadic Procedures		
March Marc	00331		Policy (CPCP).	301703.023	Computer-Assisted Navigation for Orthopedic Procedures	-	-
No.	0062U	Ai Sie igg&igm Alys 80	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED207.159	Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases	_	_
Page			FILL Procedure (service not reimbursed by the Plan Not subject to pre-service				
Part	0063U		review. Check Elu policy CPCPU8, which is one of our Clinical Payment and Coding	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
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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	Quantitative Sensory Testing	_	_
0108U		Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0109T	Bmrk Heat Quant Sensory Test	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	MED205 020	Quantitative Sensory Testing		
	Id Aspergillus Dna 4	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	WED203.030	Qualitative Jelisory restilig	-	-
0109U	Species	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	-	-	-	-
0110T		review. Check EIU policy CPCP08, which is one of our $$ Clinical Payment and Coding Policy (CPCP).	MED205.030	Quantitative Sensory Testing	-	-
0110U	Rx Mntr 1+Oral Onc Rx&Sbsts	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0111U	Alys ladi 16S&18S Rrna	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0112U	Genes Onc Prst8	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0113U	Pca3&Tmprss2-Erg Gi Barretts Esoph	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0114U 0115U	Vim&Ccna1 Respir ladna 18 Viral&2	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0116U	Bact Rx Mntr Nzm Ia 35+Oral		-	-	-	-
01100 0117U	Flu Pain Mgmt 11	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0118U	Endogenous Anal Trnsplj Don-Drv Cll-Fr	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
0119U	Ona Crd Ceramides Liq	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
0120U	Onc B Cll Lymphm Mrna 58 Gen	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.	-	-	-	-
0129U	Hered Brst Ca Ritd Do Panel	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
0130U	Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 Pnl 17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0133U	11	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0134U	18 Gen Hered Gyn Ca Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0135U	12 Gen	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0136U 0137U	Atm Mrna Seq Alys Palb2 Mrna Seq Alys	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
01370 0138U	Brca1 Brca2 Mrna Seq	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	Alys Neuro Austm Meas 6 C	service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	_	-	-	_
0139U	Metablt	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014	Autism Spectrum Disorders (ASD)	-	9/30/2021
0140U	Nfct Ds Fungi Dna 15 Trgt Nfct Ds Bact&Fng Gram	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0141U	Pos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0142U	Neg Drug Assay 120+	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0143U	Rx/Metablt Drug Assay 160+	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0144U 0145U	Rx/Metablt Drug Assay 65+	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0145U	Rx/Metablt Drug Assay 80+	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
0147U	Rx/Metablt Drug Assay 85+ Rx/Metablt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_	_	_
0148U	Drug Assay 100+ Rx/Metablt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	_	_
0149U	Drug Assay 60+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	_	_	_
0150U	Drug Assay 120+ Rx/Metablt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0151U	Nfct Bct/Vir Resp Nfctj 33	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
0152U	Nfct Ds Dna Untrgt Ngnrj Seq	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
0153U	Onc Breast Mrna 101 Genes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0154U	Onc Urthl Ca Rna Fgfr3 Gene Onc Bret Ca Dna Bik3Ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0155U	Gene Copy Number Sequence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0156U	Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
0157U	Apc Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
015011						
0158U 0159U	Mih1 Mrna Seq Alys Msh2 Mrna Seq Alys	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	

0160U	Msh6 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
0161U	Pms2 Mrna Seq Alys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0162U	Hered Colon Ca Trgt Mrna Pnl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
0191T	Insert Ant Segment Drain Int	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	5/1/2021	_
0198T	Ocular Blood Flow Measure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.022	Ophthalmologic Techniques For Evaluating Glaucoma	-	-
0202T	Post Vert 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	Facet Arthroplasty	-	_
0207T	Clear Eyelid Gland W/Heat	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	_	-
0219T	Plmt Post Facet Implt Cerv	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	SUR712.032	Isolated Facet Joint Fusion	_	_
0220T	Plmt Post Facet Implt Thor	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	SUR712.032	Isolated Facet Joint Fusion	_	_
0221T	Plmt Post Facet Implt Lumb	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	SUR712.032	Isolated Facet Joint Fusion	_	_
0222T	Plmt Post Facet Implt	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	SUR712.032	Isolated Facet Joint Fusion		
	Addl	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.101	Orthopedic Applications of Platelet-Rich Plasma	-	-
0232T	Njx Platelet Plasma Insert Aqueous Drain	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	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
0253T	Device Device	predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	-	-
0263T	Im B1 Mrw Cel Ther Cmpl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
0264T	Im B1 Mrw Cel Ther Xcl Hrvst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
0265T	Im B1 Mrw Cel Ther 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).	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
0278T	Tempr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	_	-
0312T	Laps Impltj Nstim Vagus	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	_
0313T	Laps Rmvl Nstim Array	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	Vagus Laps Rmvl Vgl Arry&Pls	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	
	Gen Rmvl Vagus Nerve Pls	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				-
0315T	Gen Replc Vagus Nerve Pls	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	-
0316T	Gen	require Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	-
0317T	Elec Alys Vagus Nrv Pls Gen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	-
0330T	Tear Film Img Uni/Bi W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	-	-
0331T	Heart Symp Image Pinr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD604.012	Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure	4/1/2021	_
0335T	Insj Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR705.027	Subtalar Arthroereisis (STA)	-	-
0338T	Trnscth Renal Symp Denrv Unl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0339T	Trnscth Renal Symp Denrv Bil	Foliary (CPCP). Foliary (CPCP).	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0347T	Ins Bone Device For Rsa	Folicy (CPCP). Folicy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0348T	Rsa Spine Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0349T	Rsa Upper Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0350T	Rsa Lower Extr Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0352T	Oct Brst/Node I&R Per Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.053	Optical Coherence Tomography of the Breast	_	_
0354T	Oct Breast Surg Cavity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.053	Optical Coherence Tomography of the Breast	_	_
0355T	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 Policy (CPCP)	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon	-	_
0358T	Bia Whole Body	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	RAD601.045	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA)	_	-
0376T	Insert Ant Segment	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma		
0378T	Drain Int Visual Field Assmnt	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Home-Based Monitoring of Visual Field	_	-
0379T	Rev/Rprt Vis Field Assmnt Tech	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		Home-Based Monitoring of Visual Field	_	-
03/91 0397T	Suppt Ercp W/Optical	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-	-
0397T 0398T	Endomicroscpy Mrgfus Strtctc Les Abltj	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		Confocal Laser Endomicroscopy (CLE) Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)	-	-
	Colgn Cross-Link Crn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
0402T	Med Sep	predetermination to avoid post-service review.	OTH903.028	Corneal Collagen Cross-Linking	-	-

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
0423T	Assay Secretory Type Ii Pla2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	-	-
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 Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0425T	Insj/Rplc Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0426T	Insj/Rplc Nstim Apnea Stm Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0427T	Insj/Rplc Nstim Apnea Pls Gn	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0428T	Rmvl Nstim Apnea Pls Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0429T	Rmvl Nstim Apnea Sen Ld	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0430T	Rmvl Nstim Apnea Stimj Ld	FILL 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	EIU: Procedure/service 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	_
0432T	Repos Nstim Apnea Stimj Ld	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0433T	Repos Nstim Apnea Sensing Ld	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
0434T	Interro Eval Npgs Apnea	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0435T	Prgrmg Eval Npgs Apnea 1 Ses	review. Check EIU policy CPCPU8, 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	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	_
0444T	1St Plmt Drug Elut Oc	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	_	_
0445T	Sbsqt Plmt Drug Elut Oc	review. Check EIU policy CPCPU8, which is one of our Clinical Payment and Coding	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	_	_
0449T	Insj Aqueous Drain Dev	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma		
0450T	1St Insj Aqueous Drain Dev	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	-	-
0464T	Visual Ep Test For Glaucoma	predetermination to avoid post-service review. EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding		Visual Evoked Potential Testing for Glaucoma	-	-
0465T	Supchrdl Njx Rx W/O Supply	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OTH903.035	Suprachoroidal Injection of a Pharmacologic Agent	_	_
0466T	Insj Ch Wal Respir	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management		
0470T		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	_
0471T	1St Oct Skn Img Acquisj I&R	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	-
04711	Addl	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.023	Optical Diagnostic Devices for Evaluating 5xim Lesions Suspected of Malignancy	10/1/2021	-
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		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Retinal Prosthesis	-	-
0474T	Rsvr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		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.		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. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR716.001	Cosmetic and Reconstructive Procedures	4/1/2021	-
0485T	Oct Mid Ear I&R Unilateral	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	-	-
0486T	Oct Mid Ear I&R Bilateral	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.046	Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions	-	-
0493T	Near Ifr Spectrsc Of Wounds	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.006	Foot Care Services	-	-
0499T	Cysto F/Urtl Strix/Stenosis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR710.026	Optilume (Drug Coated Balloon) for the Treatment of Urethral Stricture Conditions	-	-
0507T	Near Ifr 2Img Mibmn Glnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	-	-
0508T	Pls Echo Us B1 Dns Meas Tib	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.071	Pulse-Echo Ultrasound Bone Density Measurement	-	-
0509T	Pattern Erg W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.036	Electroretinography (ERG), Multi-Focal Electroretinography (mfERG) And Pattern Electroretinography (PERG)	5/15/2021	-
0511T	Rmvl&Rinsj Sinus Tarsi Implt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	-	-
0512T	Esw Integ Wnd Hlg 1St Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0513T	Esw Integ Wnd Hlg Ea Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP)		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	-
032-11	**/6					

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 Repri Cnfig	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0536T	Cont Rec Mvmt Do DI W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	-	-
0548T	Tprnl Balo Cntnc Dev Bi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	-	-
0549T	Tprnl Balo Cntnc Dev Uni	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	-	-
0550T	Tprnl Balo Cntnc Dev Rmvl Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	-	-
0551T	Tprnl Balo Cntnc Dev Adjmt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	-	-
0563T	Evac Meibomian Glnd Heat Bi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU)	-	-
0565T	Autol Cell Implt Adps	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone	4/1/2021	8/14/2021
0565T	Autol Cell Implt Adps Hrvg	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		Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	8/15/2021	_
	·	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone		
0566T	Autol Cell Implt Adps Njx	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Marrow) Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous	4/1/2021	8/14/2021
0566T		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	SUR703.051 MED205.035	Bone Marrow)	8/15/2021	-
0587T	Ptn	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	-
0588T	Ptn	predetermination to avoid post-service review.	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	-
0589T	Elec Alys Smpl Prgrmg lins	predetermination to avoid post-service review.	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	_
0590T	Elec Alys Cplx Prgrmg lins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED205.035	Percutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	_
0602T	Transdermal Gfr Measurements	Ellu: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	-
0603T	Transdermal Gfr Monitoring	Folicy (CPCP). Eliu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check ElU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	-
0615T	Eye Mvmt Alys W/O Calbrj I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
0620T	Evasc Ven Artlz 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	-
0621T	Trabeculostomy Interno Laser	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0622T	Trabeculostomy Int Lsr W/Scp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0623T	Auto Quantification C Plaque	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0624T	Auto Quan C Plaq Data Prep	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0625T	Auto Quan C Plaq Cptr Alys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0626T	Auto Quan C Plaq I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0627T	Perq Njx Algc Fluor Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0628T	Perq Njx Algc Fluor Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0629T	Perq Njx Algc Ct Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0630T	Perq Njx Algc Ct Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0631T	Tc Vis Lit 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	-
0632T	Perq 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	-
0639T	Wrls Skn Snr Anisotropy Meas	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2021	-
0640T	Nente Nr Ifr Spetrse Wnd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
0641T	Ncntc Nr Ifr Spctrsc Wnd Img	Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
0642T	Nente Nr Ifr Spetrse Wnd I&R	Policy (CPCP). MD Citaria Page due (conject explanate against Medical Policy Citaria Submit for		Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
0643T	Tcat L Ventr Rstrj Dev Implt	predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
0645T	Tcat 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	-

00407	Ttvi/Rplcmt W/Prstc Vlv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			7/4/2024	
0646T	Perq Prgrmg Dev Eval Scrms	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADIVI1001.032	Experimental, Investigational and/or Unproven Procedures/Services Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors,	7/1/2021	-
0650T	Remote	predetermination to avoid post-service review.	MED202.003	and Intracardiac Ischemia Detection Systems)	7/1/2021	-
0656T	Vrt Bdy Tethering Ant <	, EIU.: Procedure/service not reimbursed 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	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	7/1/2021	-
0657T	Vrt Bdy Tethering Ant 8- Seg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	7/1/2021	-
0658T	Elec Impd Spectrsc 1+Skn Les	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.023	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy	10/1/2021	_
0664T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0664T	Don Hysterectomy Open	FILE Procedure/service not reimbursed by the Plan. Not subject to pre-service	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	
	Cdvr Don Hysterectomy Open	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				0/44/2024
0665T	Liv Don Hysterectomy Open	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0665T	Liv	Policy (CPCP)		Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0666T	Don Hysterectomy Laps Liv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0666T	Don Hysterectomy Laps Liv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0667T	Don Hysterectomy Rcp Uter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0667T	Don Hysterectomy Rcp Uter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	_
0668T	Bkbench Prep Don Uter	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for producer and produce and p	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0668T	Algrft Bkbench Prep Don 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	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	
	Algrft Bkbench Rcnstj Don Ute	Policy (CPCP). r MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				0/14/2024
0669T	Ven Bkbench Rcnstj Don Ute	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0669T	Ven	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
0670T	Bkbench Rcnstj Don Ute Arti	r MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
0670T	Bkbench Rcnstj Don Ute Artl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	OB402.023	Services for Infertility and Recurrent Fetal Loss	8/15/2021	-
A0430	Fixed Wing Air Transpor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0431	Rotary Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0435	Fixed Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0436	Rotary Wing Air Mileage	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for processing the standard services and processing the standard services.	ADM1001.005	Ambulance and Medical Transport Services		
A0888		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Ambulance and Medical Transport Services	_	_
A0888 A0999	Mileage Unlisted Ambulance	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	ADM1001.005		-	
A0999	Mileage	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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	ADM1001.005		-	-
A0999 A4267	Mileage Unlisted Ambulance Service Male Condom Sacral Nerve Stim Test	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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	ADM1001.005	Ambulance and Medical Transport Services -	-	-
A0999	Mileage Unlisted Ambulance Service Male Condom	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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	ADM1001.005 SUR710.018		-	-
A0999 A4267 A4290	Mileage Unlisted Ambulance Service Male Condom Sacral Nerve Stim Test Lead	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -		
A0999 A4267 A4290 A4335	Mileage Unlisted Ambulance Service 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. 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 preservice 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. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -	-	-
A0999 A4267 A4290 A4335 A4421	Mileage Unilsted Ambulance Service Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -	-	-
A0999 A4267 A4290 A4335 A4421 A4458	Mileage Unilisted Ambulance Service Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. Onn Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -	-	-
A0999 A4267 A4290 A4335 A4421 A4458 A4520	Mileage Unlisted Ambulance Service Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -	- - - - - - -	-
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553	Mileage Unilsted Ambulance Service 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	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services -		-
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555	Mileage Unilsted Ambulance Service Male Condom Sacral Nerve Stim Test Lead Incontinence Supply Ostomy Supply Misc Reusable Enema Bag Incontinence Garment Anytype Nondisp Underpads All Sizes Disposable Underpads	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. ElU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation		-
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A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4575 A4600 A4639 A4641 A4649 A4890 A4913 A4927	Mileage Unlisted Ambulance Service 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 Repicmn 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 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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. 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 preservice review. Check EIU policy CPCPOB, which is one of our Clinical Payment and Coding Policy (CPCP). PA maybe required until 04/01/2022. MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to preservice review. Check EIU policy CPCPOB, which is one of our Clinical Payment and Coding Policy (CPCP). PA maybe required until 04/01/2022. MP Criteria: 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 contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non C	ADM1001.005 SUR710.018 MED201.039 PSY301.014 THE801.003 MED202.060 MED202.073 DME101.045	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation Tumor Treating Fields (TTF) Therapy Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis		
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4575 A4600 A4639 A4641 A4649 A4890 A4913 A4927	Mileage Unilsted Ambulance Service 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 Sieve Inter Limb Comp Dev Infrared Ht Sys Replcmn Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves Reusable Oral Thermometer Reusable Rectal	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. EIU: Procedure/service not reimbursed by the Plan. Not subject to preservice review. EIU: Procedure/service not reimbursed by the Plan. Not subject to preservice review. EIU: Procedure/service not reimbursed by the Plan. Not subject to preservice review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Pa maybe required until 04/01/2022. 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 preservice review. Procedure/service not reimbursed by the Plan. Not subject to preservice review. Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Unlisted: Procedure/service not specific	ADM1001.005 SUR710.018 MED201.039 PSY301.014 THE801.003 MED202.060 MED202.073 DME101.045	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation Tumor Treating Fields (TTF) Therapy Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis		
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4575 A4600 A4639 A4641 A4649 A4890 A4913 A4927 A4931 A4932	Mileage Unilsted Ambulance Service 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 Sieve Inter Limb Comp Dev Infrared Ht Sys Repicmn 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 Reusable Rectal Thermometer Reusable Rectal	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. EIU: Procedure/service not reimbursed by the Plan. Not subject to preservice review. Check EIU policy CPCDB, which is one of our Clinical Payment and Coding Policy (CPCP). A maybe required until 04/01/2022. MP Criteria: Procedure/service not specifically defined or classified, may be subject to preservice review. Check EIU policy CPCDB, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: 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 s	ADM1001.005 SUR710.018 MED201.039 PSY301.014 THE801.003 MED202.060 MED202.073 DME101.045	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation Tumor Treating Fields (TTF) Therapy Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis		
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4575 A4600 A4639 A4641 A4649 A4890 A4913 A4927 A4931 A4932 A5507	Mileage Unlisted Ambulance Service 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 Replcmn Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves Reusable Oral Thermometer Modification Diabetic Shoe Wound Warming Wound Cover Wound Filler Gel/Paste /Oz	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice 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. Application of 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). PA maybe required until 04/01/2022. MP Criteria: 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 contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. No	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation Tumor Treating Fields (TTF) Therapy Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Skin Contact Monochromatic Infrared Energy (MIRE)		
A0999 A4267 A4290 A4335 A4421 A4458 A4520 A4553 A4554 A4555 A4600 A4639 A4641 A4649 A4890 A4913 A4927 A4931 A4932 A5507 A6000	Mileage Unlisted Ambulance Service 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 Replcmn Pad Radiopharm Dx Agent Noc Surgical Supplies Repair/Maint Cont Hemo Equip Misc Dialysis Supplies Noc Non-Sterile Gloves Reusable Oral Thermometer Modification Diabetic Shoe Wound Warming Wound Cover Wound Filler Gel/Paste /Oz	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. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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. 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 preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not covered by the Plan. Not subject to preservice review. MP Criteria: Procedure/service not review 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 CPCDB, which is one of our Clinical Payment and Coding Policy (CPCP). A maybe required until 04/01/2022. MP Criteria: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Check EIU policy CPCDB, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. Non Covered: Procedur	ADM1001.005 SUR710.018	Ambulance and Medical Transport Services Sacral Nerve Neuromodulation/Stimulation Tumor Treating Fields (TTF) Therapy Autism Spectrum Disorders (ASD) Hyperbaric Oxygen (HBO2) Therapy Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Skin Contact Monochromatic Infrared Energy (MIRE)		

A6512	Compres Burn Garment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
A6549	G Compression Stocking	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
A9150	Misc/Exper Non- Prescript Dru	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
A9152	Single Vitamin Nos	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
A9153	Multi-Vitamin Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.				
	Non-Covered Item Or	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
A9270	Service	service review.	-	-	-	-
A9273	Hot/Cold Botle/Cap/Col/Wrap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
A9279	Monitoring Feature/Devicenoc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
A9280	Alert Device Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
A9282	Wig Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
A020F	Inversion Eversion Cor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	D145400 004			
A9285	Devic	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DIVIE103.001	Orthotics	-	-
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
A9579	Gad-Base Mr Contrast Nos 1MI	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	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_			
A9698	Noc Non-Rad Contrast	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
A9699	Materialnoc Radiopharm Rx Agent	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		_	_
	Noc Supply/Accessory/Servic	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-		-	-
A9900	e Dme Supply Or	contract/Clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
A9999	Accessory Nos	contract/clinical review.	-	-	-	-
B4105	Enzyme Cartridge Enteral Nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.011	Nutritional Support	-	-
B9998	Enteral Supp Not Otherwise C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
B9999	Parenteral Supp Not Othrws C	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
C1052	Hemostatic Agent Gi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADM1001 022	Evantimental Investigational and/or Unarrayan Procedures/Consistor	5/15/2021	
C1032	Topic	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
C1764	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.024	Unicondylar Interpositional Spacer as a Treatment of 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 post-service review.	3UK/13.U34	Aqueous Shunts and Stents for Glaucoma	_	_
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.030	Keratoprosthesis	_	_
	Gen Neuro Trans	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
C1823	Sen/Stim	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	4/1/2022	-
C1825	Gen Neuro Carot Sinus Baro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.034	Baroreflex Stimulation Devices	2/1/2021	-
C1841	Retinal Prosth Int/Ext	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.026	Retinal Prosthesis		
	Comp	Policy (CPCP).	3017 13.020	Tellar 1 (Stress)	-	-
C1842	Retinal Prosth Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR713.026	Retinal Prosthesis	_	_
C1990	Implant/Insert Device	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to				
C1889	Noc	contract/clinical review.	- SUR701 041	Endovascular Therapies for Extracranial Vertebral Artery Disease	-	-
C2623	Cath Translumin Drug- Coat	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.028 SUR701.027	Extracranial Carotid Angioplasty or Stenting Intracranial Stenting or Angioplasty, including Endovascular Procedures	-	-
C2624	Wireless Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	_	_
C2698	Sensor Brachytx Stranded Nos	predetermination to avoid post-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	-			_
C2699	Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
C9081	Idecabtagene car pos t Inj Avalglucosid Alfa-	predetermination to avoid post-service reviewed against Medical Policy Criteria. John for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	KX5U2.Ub1	Oncology Medications	10/1/2021	-
C9085	Ngpt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#IN/A	#N/A	1/1/2022	-
C9257	Bevacizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	OTH903.027 OTH903.020	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions	_	_
	Veriter C !!	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		
C9354	Veritas Collagen Matrix Cm2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9356	Tenoglide Tendon Prot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUB704 043	Biographograd Chin and Coft Tizzu Cubethite		
C3330	Cm2	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	3UK/U4.U1Z	Bioengineered Skin and Soft Tissue Substitutes	-	-
	Dermal Substitute					
C9358	Native Non-Denatured Collagen Fetal Bovine	EIU: Procedure/service 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		
	Collagen Matrix) Per 0.5	Policy (CPCP)				
	Square Centimeters					
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	EIU: Procedure/service 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	_	_
	Implnt,bon void filler-	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may		Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous	4/4/0	
C9362	strip	require Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR703.051	Bone Marrow)	4/1/2021	-
C9363	Integra Meshed Bil Wound Mat	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
		Policy (CPCP).				

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 SUR704.012 Policy (CPCP).	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. RX501.099 RX501.110	-	-	-
C9739	Cystoscopy Prostatic Imp 1-3	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Prostatic Urethral Lift	_	_
C9740	Cysto Impl 4 Or More Revascularization, Endovascular, Open Or Percutaneous, Any	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	Prostatic Urethral Lift	-	-
C9764	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 #N/A predetermination to avoid post-service review.	#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	5/15/2021	-
C9766	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy And Atherectomy, Includes Angloplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A predetermination to avoid post-service review.	#N/A	5/15/2021	-
C9767	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S), With Intravascular Lithotripsy And Transluminal Stent Placement(S), And Atherectomy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A predetermination to avoid post-service review.	#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 SUR701.043 Policy (CPCP).	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	3/1/2021	_
C9769	Cysto W/Temp Pros Implant	MED201.025 MED201.025 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.	Gene Therapy for Inherited Retinal Dystrophy	4/1/2021	-
C9771	NsI/Sins Cryo Post Nasal Tis	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR706.001 Policy (CPCP).	Nasal and Sinus Surgery	5/15/2021	-
C9772	Revasc lithotrip tibi/perone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	5/15/2021	8/14/2021
C9772	Revasc lithotrip tibi/perone	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9773	Revasc lithotr-stent	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A	#N/A	5/15/2021	8/14/2021
C9773	tib/per Revasc lithotr-stent tib/per	predetermination to avoid post-service review. EIU- Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C0774	Revasc lithotr-ather	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A	#NI/A	5/15/2024	9/14/2024
C9774	tib/per Revasc lithotr-ather	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy (PCPB), which is one of our Clinical Payment and Coding ADM1001.032	#N/A Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021 8/15/2021	8/14/2021
C9775	tib/per Revasc lith-sten-ath	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for #N/A	#N/A	5/15/2021	8/14/2021
C9775	tib/per 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 review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9777	Esophag Mucosal Integ Add-On	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	EIU Procedures/Services	8/15/2021	_
C9898	Inpnt Stay Radiolabeled	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to			
C9898 C9899	Item Inpt Implant Pros Dev No Cov	contract/clinical review. — Unlisted: Procedure/service not specifically defined or classified, may be subject to — — — — — — — — — — — — — — — — — — —		-	-
D0999	Unspecified Diagnostic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.		_	_
D1705	AstraZeneca Covid-19 vaccine administration —	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	3/15/2021	_
D1706	first dose AstraZeneca Covid-19 vaccine administration —	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		3/15/2021	
	second dose	service review.		-,,	-

D1999	Unspecified Preventive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D2999	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	-	_
D3410	Apicoectomy - Anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
D3999	Unspecified Endodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
D4999	Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D5899	Unspecified Removable Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
	Extraction Erupted Tooth Requiring					
D7210	Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
	Mucoperiosteal Flap If Indicated					
D7220	Removal Of Impacted Tooth - Soft Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
D7230	Removal Of Impacted Tooth - Partially Bony	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
D7999	Unspecified Oral Surgery Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D8210	Removable Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
D8220	Fixed Appliance Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
D8999	Unspecified Orthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
D9999	Unspecified Adjunctive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0210	Electric Heat Pad Standard	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
E0217	Water Circ Heat Pad W Pump	service review.	-	-	-	-
E0218	Fluid Circ Cold Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	-	-
E0231	Wound Warming Device	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0232	Warming Card For Nwt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0236	Pump For Water Circulating P	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
E0240	Bath/Shower Chair	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
E0241	Bath Tub Wall Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
E0242	Bath Tub Rail Floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
E0243	Toilet Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
E0244	Toilet Seat Raised	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
E0245	Tub Stool Or Bench Transfer Tub Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
E0246	Attachment Trans Bench W/Wo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
E0247	Comm Open Hdtrans Bench W/Wo	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
E0273	Comm Open Bed Board	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				_
E0274	Over-Bed Table	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_	_	_
E0300	Enclosed Ped Crib Hosp Grade		DME101.001	Hospital Beds and Related Equipment	_	-
E0315	Bed Accessory Brd/Tbl/Supprt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
E0316	Bed Safety Enclosure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	-	-
E0446	Topical Ox Deliver Sys Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-

	Oral Device/Appliance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
E0485	Prefab	require Prior Authorization per contract agreement.	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	-	-
E0486	Oral Device/Appliance Cusfab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	-	-
E0487	Electronic Spirometer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Home Spirometry	-	-
E0616	Cardiac Event Recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
E0625	Patient Lift Bathroom Or Toi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E0635	Patient Lift Electric	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0637	Combination Sit To Stand Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0638	Standing Frame Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0641	Multi-Position Stnd Fram Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0642	Dynamic Standing Frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.034	Lifts, Elevators, and Standing Frames/Systems	-	-
E0650	Segment	 MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. 	MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0651	Pneum Compressor Segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0652	Pneum Compres W/Cal Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0655	Pneumatic Appliance Half Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_
E0656	Segmental Pneumatic Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	_	_
E0657	Segmental Pneumatic Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	_	_
E0660	Pneumatic Appliance	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
E0665	Full Leg Pneumatic Appliance	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	-	-
E0666	Full Arm Pneumatic Appliance	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.073 MED202.060	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	-	-
	Half Leg Seg Pneumatic Appl Full	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.073 MED202.060	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	-	-
E0667	Leg Seg Pneumatic Appl Full	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.073 MED202.060	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	-	-
E0668	Arm Seg Pneumatic Appli	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.073	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	-	-
E0669	Half Leg	predetermination to avoid post-service review.	MED202.073	Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0670	Seg Pneum Int Legs/Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0671	Pressure Pneum Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0672	Pressure Pneum Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0673	Pressure Pneum Appl Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0675	Pneumatic Compression Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0676	Inter Limb Compress Dev Nos	MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0691	Uvl Pnl 2 Sq Ft Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
E0692	Uvi Sys Panel 4 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE8U1.033	Phototherapy for Dermatologic Conditions	-	-
E0693	Uvl Sys Panel 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Phototherapy for Dermatologic Conditions	-	-
E0694	Uvl Md Cabinet Sys 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		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)	-	-
E0740	Non-Implant Pelv Flr E- Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.037 MED201.030	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence Sexual Dysfunctions, Assessment and Treatment	-	-
E0745	Neuromuscular Stim For Shock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018 MED201.026	Sacral Nerve Neuromodulation/Stimulation Surface Electrical Stimulation	_	_
E0747		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.044	Electrical Sone Growth Stimulation of the Appendicular Skeleton	_	_
E0748	Elec Osteogen Stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.013	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	_	_
E0749	Spinal Elec Osteogen Stim	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR705.013	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	_	
E0760	Osteogen Ultrasound	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.044 DME101.030	Electrical Bone Growth Stimulation of the Appendicular Skeleton Low Intensity Pulsed Ultrasound Fracture Healing Device		
E0761		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	_
E0762	Device Trans Elec Jt Stim Dev Sys	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		Electrical Stimulation for the Treatment of Arthritis	-	_
E0764	Functional	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
	Neuromuscularstim Functional	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service			-1 -1 -0	
E0764	Neuromuscularstim	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	MED201.033	Functional Neuromuscular Electrical Stimulation	-	6/30/2021
E0764	Functional Neuromuscularstim	review. Check EIU policy CPCP08, which is one of our $$ Clinical Payment and Coding Policy (CPCP).		Functional Neuromuscular Electrical Stimulation	4/1/2022	-
E0766	Elec Stim Cancer Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	-	-
E0769	Electric Wound Treatment Dev	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	-
E0770	Functional Electric Stim Nos	MM Criteria: Procedure/service not specifically defined or classified. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	MED201.033	Functional Neuromuscular Electrical Stimulation	-	-
E0830	Ambulatory Traction Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041	Pneumatic Traction and Spinal Unloading Devices	-	-

E0840	Tract Frame Attach Headboard	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0849	Cervical Pneum Trac Equip	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	_	-
E0850	Traction Stand Free Standing	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0855	Cervical Traction Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0856	Cervic Collar W Air Bladders	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.041 DME101.046	Pneumatic Traction and Spinal Unloading Devices Traction Devices for Use in the Home	-	-
E0860	Tract Equip Cervical Tract	Ellu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0890	Traction Frame Attach Pelvic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0935	Cont Pas Motion Exercise Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.023	Continuous Passive Motion (CPM) Device	-	-
E0936	Cpm Device Other Than Knee	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.023	Continuous Passive Motion (CPM) Device	-	-
E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.046	Traction Devices for Use in the Home	-	-
E0985	W/C Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E0986	Man W/C Push-Rim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1002	Powr System 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	_	_
		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	DIVIETOT.010	Wheelchairs and Accessories	-	-
E1004	Pwr Seat Recline Mech	predetermination to avoid post-service review.	DIVIETOT.010	Wheelchairs and Accessories	-	-
E1005	Pwr Seat Recline Pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1006	Pwr Seat Combo W/O Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1007	Pwr Seat Combo	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1008	W/Shear Pwr Seat Combo Pwr	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
	Shear	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIMETOT.010	wheelchairs and Accessories	-	-
E1009	Add Mech Leg Elevation	predetermination to avoid post-service review.	DIVIETUT.010	Wheelchairs and Accessories	-	-
E1010	Add Pwr Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1012	Ctr Mount Pwr Elev Leg Rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1161	Manual Adult Wc W	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1229	Tiltinspac Pediatric Wheelchair	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
	Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
E1230 E1239	Power Operated Vehicle Ped Power Wheelchair	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria. Unlisted: Procedure/service not specifically defined or classified, may be subject to	DIMETOT.010	Wheelchairs and Accessories Wheelchairs and Accessories	-	-
	Nos	contract/clinical review.			-	_
E1399	Durable Medical Equipment Mi	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
E1699	Dialysis Equipment Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	- DMF103.009	-	-	-
E1700	Jaw Motion Rehab System	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	SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1701	Repl Cushions For Jaw Motion	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	50K705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1702	Repl Measr Scales Jaw Motion	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	30K705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1902	Aac Non-Electronic Board	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Autism Spectrum Disorders (ASD) Speech Generating Devices (SGD)	-	-
E2300	Pwr Seat Elevation Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2301	Pwr Standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2310	Electro Connect Btw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2311	Control Electro Connect Btw 2	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	_	_
E2312	Sys Mini-Prop Remote	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2313	Joystick Pwc Harness Expand	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
	Control	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
E2321	Hand Interface Joystick	predetermination to avoid post-service review.	DIVIE101.010	Wheelchairs and Accessories	-	-
E2322	Mult Mech Switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE101.010	Wheelchairs and Accessories	-	-
E2323	Special Joystick Handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2324	Chin Cup Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2325	Sip And Puff Interface	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
E2326	Breath Tube Kit Head Control Interface	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	. DIVIETOT.010	Wheelchairs and Accessories	-	-
E2327	Mech	predetermination to avoid post-service review.	DIVIETUT.010	Wheelchairs and Accessories	-	-
E2328	Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2329	Head Control Nonproportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_

E2330	Head Control Proximity Switc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2331	Attendant Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2340		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2341	Frame W/C Wdth 24-27 In Seat	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
	Frame W/C Dpth 20-21 In Seat	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
E2342	Frame	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIVIETOT.010	Wheelchairs and Accessories	-	-
E2343	Frame	predetermination to avoid post-service review.	DIVIETOT.010	Wheelchairs and Accessories	-	-
E2351	Electronic Sgd Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2373	Hand/Chin Ctrl Spec Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2374	Hand/Chin Ctrl Std Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2375	Non-Expandable Controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2376	Expandable Controller	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2377	Repl Expandable Controller	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		_
E2500	Initl Sgd Digitized Pre-Rec	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
	<=8Min Sgd Prerec Msg >8Min	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIVIE104.009	Speech Generating Devices (SGD)	-	-
E2502	<=20Min	predetermination to avoid post-service review.	DIVIE 104.005	Speech Generating Devices (SGD)	-	-
E2504	Sgd Prerec Msg>20Min <=40Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE 104.005	Speech Generating Devices (SGD)	-	-
E2506	Sgd Prerec Msg > 40 Min	predetermination to avoid post-service review.	DIVIE 104.005	Speech Generating Devices (SGD)	-	-
E2508	Sgd Spelling Phys Contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2510	Sgd W Multi Methods Msg/Accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2511	Sgd Sftwre Prgrm For	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	_
E2512	Pc/Pda Sgd Accessory	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	_
LLJIL	Mounting Sys	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.	DIVICIO4.003	Speech deficialing bevices (Sdb)	-	-
E2599	Sgd Accessory Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2610	Powered W/C Cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
G0176	Opps/Php;Activity	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)		
	Therapy	predetermination to avoid post-service review.			_	_
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	-	-	-	-
G0255	Current Percep	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED205.033	Automated Point-of-Care Nerve Conduction Testing		
G0233	Threshold Tst	Policy (CPCP).	MED205.030	Quantitative Sensory Testing	-	-
G0276	Pild/Placebo Control Clin Tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	_	_
G0281	Elec Stim Unattend For	EIU: Procedure/service 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		
00101	Press	Policy (CPCP).	WED201.027	Electrostalination and Electromagnetic Therapy for Treating Woulds	-	_
G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	_	_
C0202	Non-Cov Surg Proc Clin	Policy (CPCP). Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G0293	Trial Non-Cov Proc Clinical	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G0294	Trial	service review.	-	-	-	-
G0295	Electromagnetic Therapy Onc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	_	_
		Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
G0329	Electromagntic Tx For Ulcers	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non-Covered Physical Therapy Services	-	-
G0341	Percutaneous Islet	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.013	Pancreas and Related Organ Tissue Transplantation	_	_
G0342	Celltrans Laparoscopy Islet Cell	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.013	Pancreas and Related Organ Tissue Transplantation		_
	Trans Laparotomy Islet Cell	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
G0343	Transp Prostate Biopsy Any	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	50K703.013	Pancreas and Related Organ Tissue Transplantation Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with	-	-
G0416	Mthd Intens Cardiac Rehab	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	50K/17.015	Biopsy	-	-
G0422	W/Exerc	predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	-	-
G0423	Intens Cardiac Rehab No Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	-	-
	Collagen Meniscus					
G0428	Filling Meniscal Defects	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.034	Meniscal Allografts and Other Meniscal Implants	_	_
	(E.G. Cmi Collagen Scaffold Menaflex)	Policy (CPCP). PA maybe required until 04/01/2022.				
	Dermal Filler Injection(S) For The Treatment Of					
G0429	Facial Lipodystrophy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	-
	A Result Of Highly Active Antiretroviral Therapy.)					
G0455	Fecal Microbiota Prep Instil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.049	Fecal Microbiota Transplantation (FMT)	-	-
G0460	Autologous Prp For	EIU: Procedure/service 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		
	Ulcers Autolog Pro Diab Wound	Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
G0465	Ulcer	predetermination to avoid post-service review.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	4/13/2021	3/31/2022
G0465	Autolog Prp Diab Wound Ulcer	review. Check Elo policy CPCPO8, 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	4/1/2022	_
		Policy (CPCP).				

	Alcohol/Sub Misuse	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G2011	Assess	service review.	-	-	-	-
G2082	less	predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	08/01/2021	-
G2083	Visit esketamine > 56m	predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	08/01/2021	-
G8395	Lvef>=40% Doc Normal Or Mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8396	Lvef Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G8397	Dil Macula/Fundus Exam/W Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	-	_
G8399	Pt W/Dxa Results Document	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	_	_
G8400	Pt W/Dxa No Results Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8404		Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
G8405	Low Externity Neur Not	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_			_
G8410	Perfor Eval On Foot	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
G8415	Documented Eval On Foot Not	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		-	
G8416	Performed Pt Inelig Footwear	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
G8417	Evaluatio Calc Bmi Abv Up Param	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	F/U Calc Bmi Blw Low Param	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8418	F/U	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8419	Nof/U Calc Bmi Norm	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8420	Parameters	service review.	-	-	-	-
G8421	Bmi Not Calculated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8422	Pt Inelig Bmi Calculation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8427	Docrev Cur Meds By Elig Clin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G8428	Cur Meds Not Document	service review.	-	-	-	-
G8430	Doc Med Rsn No Medrec	service review.	-	-	-	-
G8431	Pos Clin Depres Scrn F/U Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	-
G8432	Dep Scr Not Doc Rng	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	_
G8433	Scr For Dep Not Cpt Doc Rsn	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	_	_
G8450		Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8451		Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G8452	Pt W/Abn Lvef B-Bloc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
G8465	No Rx High Risk Recurrence	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G8473	Pro Ca Ace/Arb Thxpy Rx?D	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			-	
G8474		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
G8475	Reas Ace/Arb Thxpy Not Rx?D	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	Bp Sys <140 And Dias	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8476	<90 Bp Sys>=140 And/Or	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8477	Dias >=90	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8478	Bp Not Performed/Doc Flu Immunize	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8482	Order/Admin	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G8483	Rea	service review.	-	-	-	-
G8484	Flu Immunize No Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
G9050	Oncology Work-Up Evaluation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9051	Oncology Tx Decision- Mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9052	Onc Surveillance For Disease	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9053	Onc Expectant Management Pt	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9054	Onc Supervision Palliative	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	-	_
G9055	Onc Visit Unspecified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_			
	Nos Onc Prac Memt Adheres	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
G9056	Guide	service review.	-	-	-	-
G9057	Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9058	W/Gui	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9059	Alterna	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9060	Comorb	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9061	Onc Prac Cond Noadd By Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9062	Onc Prac Guide Differs Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9063	Onc Dx Nsclc Stgi No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9064	Onc Dx Nsclc Stg2 No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-

G9065	Onc Dx Nsclc Stg3A No Progre	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_
G9068	Unknown Nos Onc Dx Scic/Nscic	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
	Limited Onc Dx Sclc/Nsclc Ext At	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9069	Dx Onc Dx Scic/Nscic Ext	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9070	Unknwn	service review.	-	-
G9071	Onc Dx Brst Stg1-2B Hr Nopro	service review.	-	-
G9072	Onc Dx Brst Stg1-2 Noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9073	Onc Dx Brst Stg3-Hr No Pro	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9074	Onc Dx Brst Stg3- Noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_
G9075	Onc Dx Brst Metastic/	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
G9077	Recur Onc Dx Prostate T1No	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	
G9078	Progres Onc Dx Prostate T2No	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
	Progres Onc Dx Prostate T3B-	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9079	T4Noprog	service review.	-	-
G9080	Psa	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9083	Onc Dx Prostate Unknwr Nos	n Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review. – – –	-	-
G9084	Onc Dx Colon T1-3 N1-2 No Pr	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9085	Onc Dx Colon T4 N0 W/O Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_
G9086	Onc Dx Colon T1-4 No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_
G9087	Dx Prog Onc Dx Colon Metas	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
G9088	Evid Dx Onc Dx Colon Metas	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
	Noevid Dx Onc Dx Colon Extent	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9089	Unknown	service review.	-	-
G9090	Progr	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9091	Onc Dx Rectal T3 N0 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9092	Onc Dx Rectal T1-3 N1- 2Noprg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9093		Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_
G9094	Onc Dx Rectal M1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
G9095	W/Mets Prog Onc Dx Rectal Extent	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
	Unknwn Onc Dx Esophag T1-T3	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9096	Noprog Onc Dx Esophageal T4	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9097	No Prog	service review. – – son Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9098	Recur	service review.	-	-
G9099	Onc Dx Esophageal Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9100	Onc Dx Gastric No Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9101	Onc Dx Gastric P R1- R2Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_
G9102	Onc Dx Gastric	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_
G9103	Onc Dx Gastric	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
C0104	Recurrent Onc Dx Gastric Unknown	service review. – – – n Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9104	Nos Onc Dx Pancreato P RO	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9105	Res No Onc Dx Pancreatc P	service review.	-	-
G9106	R1/R2 No	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9107	Onc Dx Pancreatic Unresectab	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9108	Onc Dx Pancreatic Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9109	Onc Dx Head/Neck T1- T2No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-
G9110		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9111	Onc Dx Head/Neck M1	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
G9112		service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	
	Unknown Onc Dx Ovarian Stg1A-B	service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9113	No Pr	service review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9114	Or 2	service review.	-	-
G9115	Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9116	Onc Dx Ovarian Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9117	Onc Dx Ovarian Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-
G9123	Onc Dx Cml Chronic Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_
G9124	Onc Dx Cml Acceler	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_
G9125	Phase Onc Dx Cml Blast Phase	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		
G9126		service review. – – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	_
	Onc Dx Cml Remission Onc Dx Multi Myeloma	service review. – – Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-
G9128	Stage I	service review.	-	-

G9129	Onc Dx Mult Myeloma Stg2 Hig	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	_	_	_
G9130	Onc Dx Multi Myeloma	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Unknown Onc Dx Brst Unknown	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
G9131	Nos Onc Dx Prostate Mets	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9132	No Cast	service review.	-	-	-	-
G9133	Onc Dx Prostate Clinical Met	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	_	-
G9134	Onc Nhlstg 1-2 No Relap No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
G9135	Onc Dx Nhl Stg 3-4 Not	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Relap Onc Dx Nhl Trans To Lg	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9136	Bcell	service review.	-	-	-	-
G9137	Onc Dx Nhl Relapse/Refractor	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
G9140	Unknown Frontier Extended Stay	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			-	
G3140	Demo	service review.	-	-	-	-
G9147	Outpatient Intravenous Insulin Treatment (Ovit) Either Pulsatin Treatment (Ovit) Either Pulsatin View (Ovit) Find Pulsatin View (Ovit) Means, Guided By The Results Of Measurements For-Respiratory Quotient; And/Or, Urine Urea Nitrogen (Uun); And/Or, Arterial, Venous Or Capillary Giucose; And/Or Potassium Concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
G9978	Remote E/M New Pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	10Mins Remote E/M New Pt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	-
G9979	20Mins	service review.	-	-	-	-
G9980	Remote E/M New Pt 30 Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
G9981	Remote E/M New Pt 45Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	- -	_	_
G9982	Remote E/M New Pt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_			
G9983	60Mins Remote E/M Est. Pt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	_
	10Mins Remote E/M Est. Pt	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
G9984	15Mins	service review.	-	-	-	-
G9985	Remote E/M Est. Pt 25Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
G9986	Remote E/M Est. Pt 40Mins	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
G9987	Bpci Advanced In Home	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	
H0046	Visit Mental Health Service	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Nos Alcohol/Drug Abuse Svc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	-	-
H0047	Nos	contract/clinical review.	-	- Abstract	-	-
J0129	Abatacept Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.113 RX501.096	Abatacept Specialty Medication Administration Site of Care	-	-
J0172	Inj Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.137	Aducanumab-avwa	1/1/2022	_
J0180	Agalsidase Beta	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_
10202	Injection Injection Alemtuzumab	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.077	Specialty Medication Administration Site of Care Alemtuzumab	_	
30202		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Criteria.	1001.077	Alcintozoniao	-	-
J0220	Alglucosidase Alfa Injection	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	-	-
	Injection Alglucosidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
J0221		require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J0222	Inj. Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	_	_
J0223	Inj Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.125	Givosiran		
	Alpha 1 Proteinase	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.096	Specialty Medication Administration Site of Care		
J0256	Inhibitor	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	- RX501.116	- Belimumab	-	-
J0490	Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J0517	Inj. Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.100 RX501.096	Benralizumab Specialty Medication Administration Site of Care	-	-
J0565	Inj Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.093	Bezlotoxumab	_	_
J0567	Inj. Cerliponase Alfa 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.092	Cerliponase alfa	_	
	Mg Injection Burosumab-	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.058	Burosumab-twza		
J0584	Twza 1M	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.019	Specialty Medication Administration Site of Care Botulinum Toxin	-	-
J0586	Abobotulinumtoxina	require Prior Authorization per contract agreement.	MED201.014	Treatment of Hyperhidrosis	-	-
J0587	Inj Rimabotulinumtoxinb	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidrosis	-	-
J0588	Injection, Incobotulinumtoxin A, 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.019 MED201.014	Botulinum Toxin Treatment of Hyperhidronic	_	_
	Unit	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	MED201.014 RX504.013	Treatment of Hyperhidrosis Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide		
J0598	C-1 Esterase Cinryze	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J0638	Canakinumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.119	Canakinumab	_	_
		require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care		
J0717	Certolizumab Pegol Inj 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.111	Certolizumab Pegol	-	_
J0717 J0775	Certolizumab Pegol Inj 1Mg				-	-

			BV504 405			
J0791	5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.126 RX501.096	Crizanlizumab-tmca Specialty Medication Administration Site of Care	3/1/2021	-
J0881	Darbepoetin Alfa Non- Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	_	_
J0885	Epoetin Alfa Non-Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)		12/31/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			_	,,
J0888	Epoetin Beta Non Esrd	require Prior Authorization per contract agreement.	RX501.069	Erythropolesis-Stimulating Agents (ESAs)	-	-
J0896	Inj luspatercept-aamt 0.25mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	_
J1096	Dexametha Opth Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.024	Intravitreal, Punctum, and Intracameral Implants		
14200	0.1 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.013	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide	_	
J1290	Ecallantide Injection	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1300	Eculizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.066 RX501.096	Eculizumab Specialty Medication Administration Site of Care	_	-
J1301		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.095	Edaravone	_	_
J1303	Mg Inj. Ravulizumab-Cwvz	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.107	Specialty Medication Administration Site of Care Ravulizumab-cwvz		
11303	10 Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1305	Inj evinacumab-dgnb 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.136	Evinacumab-dgnb	10/1/2021	-
J1322	Elosulfase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_
J1325	Farancia de la la la della del	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care		
11323	Epoprostenol Injection	require Prior Authorization per contract agreement.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	-
J1426	mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.135	Casimersen	10/1/2021	-
J1427	Vitolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.129	Viltolarsen	5/1/2021	_
11429		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	DV501 004			
J1428	Inj Eteplirsen 10 Mg	require Prior Authorization per contract agreement.	RX501.084	Eteplirsen	-	-
J1429	Inj Golodirsen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.122	Golodirsen	-	-
J1458	Galsulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_
11/150		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX504.003	Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])		
J1459	Inj Ivig Privigen 500 Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1554	Injection, Immune Globulin (Asceniv),	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	4/1/2021	_
	500Mg	predetermination to avoid post-service review.				
J1555	Inj Cuvitru 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
J1556	Inj Imm Glob Bivigam	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	_	_
	500Mg	require Prior Authorization per contract agreement.	RX501.096	specialty medication Administration site of Care		
	Injection, Immune Globulin, (Gammaplex),	NAD Calabatian Daniel Anna de la calabatian de la calabat	DVF04 003	In the state of th		
J1557	Intravenous, Non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
	Lyophilized (E.G. Liquid), 500 Mg					
11550	Ini Vombifu 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])		
J1558	Inj. Xembify 100 Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1559	Hizentra Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
J1561	Gamunex-C/Gammaked	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	_	_
14550		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care		
J1562	Vivaglobin Inj	require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
J1566	Immune Globulin Powder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
J1568	Octagam Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	_	_
11500	Gammagard Liquid	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX504.003	Specialty Medication Administration Site of Care Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])		
J1569	Injection	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1572	Flebogamma Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	-	-
J1575	Hyqvia 100Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	_	_
14500	Immuneglobulin Ivig Non-Lyophilized	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care		
J1599	Nos	require Prior Authorization per contract agreement.	RX504.003	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	-	-
J1602	Golimumab For Iv Use 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.112 RX501.096	Golimumab Specialty Medication Administration Site of Care	-	-
J1632	Inj. Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Brexanolone for Postpartum Depression	_	_
	Inj Hydroxyprogst	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
J1729	Capoat Nos	contract/clinical review.	-	- Common Deployment Theory for Lawrench Co	-	-
J1743	Idursulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
14.745	Infliximab Not Biosimil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	THE801.028	Acne Management		
J1745	10Mg	require Prior Authorization per contract agreement.	RX501.051 RX501.096	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
J1746		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.099	lbalizumab-uiyk		_
	Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.067	Specialty Medication Administration Site of Care Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
J1786	Imuglucerase Injection	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J1823	Inj. Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.127	Inebilizumab-cdon	3/1/2021	-
J1931	Laronidase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	_	_
J2182	Injection Mepolizumab	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.080	Specialty Medication Administration Site of Care Mepolizumab		
	1Mg	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care	-	-
J2278	Ziconotide Injection	require Prior Authorization per contract agreement.	RX501.060	Ziconotide	-	-
J2323	Natalizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.059 RX501.096	Natalizumab Specialty Medication Administration Site of Care	-	_
J2326	Inj Nusinersen 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Nusinersen		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.086	Nusinersen	-	-
J2350	Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2357	Omalizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.058 RX501.096	Omalizumab Specialty Medication Administration Site of Care	_	_
J2440	Papaverin Hcl Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Sexual Dysfunctions, Assessment and Treatment		
	Inj Pasireotide Long	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	MED201.030		-	-
J2502	Acting	require Prior Authorization per contract agreement.	RX501.079	Pasireotide	-	-
J2503	Pegaptanib Sodium	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.027 OTH903.020	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions		
	Injection	predetermination to avoid post-service review.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	-	-

	Injection Pegloticase 1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.120	Pegloticase		
J2507	Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2562		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J2778		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.027 OTH903.020 OTH903.015	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	_	-
J2786		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.083 RX501.096	Resilizumab Specialty Medication Administration Site of Care	_	_
J2787	Riboflavin 5'Phos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.028	Corneal Collagen Cross-Linking		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders	-	-
J2840	inj Sebelipase Alia 1 Mg	require Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2860	Injection Siltuximab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	-
J3032		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.124 RX501.096	Eptinezumab-jjmr Specialty Medication Administration Site of Care	-	_
J3060		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_
J3121	Inj Testostero Enanthate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
J3145		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.076 SUR717.001	Testosterone Replacement Therapies Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.076 RX501.096	Testosterone Replacement Therapies Specialty Medication Administration Site of Care	-	-
J3241	Trbw 10 Mg	require Prior Authorization per contract agreement.	RX501.110	Teprotumumab	-	-
J3245	Inj. Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.123	Specialty Medication Administration Site of Care Tildrakizumab-asmn	-	-
J3262	Tocilizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.115	Specialty Medication Administration Site of Care Tocilizumab	_	_
J3285	Trenrostinil Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	_
J3315		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	WIOVED TO FA IISC	12/51/2021
J3316	Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.040 RX501.096	Human Growth Hormone (GH) Specialty Medication Administration Site of Care	-	-
J3358	Mg	require Prior Authorization per contract agreement.	RX501.114	Ustekinumab	-	-
J3380	Injection Vedolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.117	Specialty Medication Administration Site of Care Vedolizumab	-	-
J3385		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_
J3396	Vertenorfin Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		
J3397		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.067	Enzyme-Replacement Therapy for Lysosomal Storage Disorders		
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096	Specialty Medication Administration Site of Care	-	-
J3398	G	require Prior Authorization per contract agreement.	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	-	-
13399		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.104	Onasemnogene Abeparvovec-xioi	-	-
J3490		Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.05 RX501.040 RX501.040 RX501.099 RX501.099 RX504.015 RX504.015 RX501.080 SUR706.001 RX501.086 RX501.086 RX501.086 RX501.086 RX501.094 RX501.040 RX501.040 RX501.040 RX501.040 RX501.040 RX501.040 RX501.040	-	_	-
J3520		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.008	Chelation Therapy	_	_
J3570	Laetrile Amygdalin Vit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
	B17	service review.	RX501.073 RX501.063 RX501.087 RX501.099			
J3590	Unclassified Biologics	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.051 RX501.080 RX501.085 RX501.104	-	-	-
13501	Esrd On Dialysi Drug/Bio	Unlisted: Procedure/service not specifically defined or classified, may be subject to	RX501.110			
13231	Noc	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
J7177	inj. Fibryga i ivig	predetermination to avoid post-service review.	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J7178	Con Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.072	Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	-
J7192		Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J7195		Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
J7199	Hemophilia Clot Factor	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
J7309	Methyl Aminolevulinate	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.027	Dermatologic Applications of Photodynamic Therapy (PDT)	_	-
J7314		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.024	Intravitreal, Punctum, and Intracameral Implants	_	_
J7316	Inj Ocriplasmin 0.125	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.026	Ocriplasmin for Symptomatic Vitreomacular Adhesion		
J7340		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			_	_
	100MI	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX504.015	Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease.	-	-
J7351	Imp1Mcg	medical Foliage and Committee Tevered against medical Foliage Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.024	Intravitreal, Punctum, and Intracameral Implants	-	-
J7402	Sinuva	predetermination to avoid post-service review.	SUR706.001	Nasal and Sinus Surgery	5/15/2021	-
J7599		Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-

		Fills December (coming and animal section) and but the Disc. Net subject to an animal				
J7604	Acetylcysteine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7607	Levalbuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7609	Albuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7610	Albuterol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7615	Levalbuterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7622	Beclomethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7624	Betamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7627	Budesonide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7628	Bitolterol Mesylate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7629	Bitolterol Mesylate Comp Unt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7632	Cromolyn Sodium Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7634	Budesonide Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7635	Atropine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7636	Atropine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7637	Dexamethasone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7638	Dexamethasone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7640	Formoterol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7641	Flunisolide Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7642	Glycopyrrolate Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7643	Glycopyrrolate Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7645	Ipratropium Bromide Comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7647	Isoetharine Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7650	Isoetharine Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7657	Isoproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7660	Isoproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7667	Metaproterenol Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7670	Metaproterenol Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7676	Pentamidine Comp Unit Dose	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7680	Terbutaline Sulf Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7681	Terbutaline Sulf Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7683	Triamcinolone Comp Con	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7684	Triamcinolone Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7685	Tobramycin Comp Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Compounded Drug Products	-	-
J7699	Inhalation Solution For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J7799	Non-Inhalation Drug For Dme	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
J7999	Compounded Drug Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_		_	_
J8498	Antiemetic Rectal/Supp	Unlisted: Procedure/service not specifically defined or classified, may be subject to	_			
J8499		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Chemo	contract/clinical review.	-	-	-	-

	Autionatic David Oral	Hallisted December (see the self-self-self-self-self-self-self-self-				
J8597	Antiemetic Drug Oral Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J8999	Oral Prescription Drug Chemo	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
J9020	Asparaginase Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
J9022	Inj Atezolizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			-	
J9023	Mg Injection Belinostat	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A	-	10/10/2021
J9032	10Mg	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9035	Bevacizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	OTH903.027 OTH903.020	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions	_	12/31/2021
		require Filor Addionization per contract agreement.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		
J9037	Injection, Belantamab Mafodontin-Blmg, 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	-
J9039	Injection Blinatumomab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	_	_
J9043		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
J9044	Mg Inj Bortezomib Nos 0.1	require Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Mg Injection Carfilzomib 1	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	-	- -	-	-
J9047	Mg	require Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
J9057	Inj. Copanlisib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	-
J9119	Inj. Cemiplimab-Rwlc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	-
J9144	Daratumumab Hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9145		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
35143	10 Mg	require Prior Authorization per contract agreement.			-	20/ 10/ 2021
J9153	Inj Daunorubicin Cytarabine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9155	Degarelix Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9173	Inj. Durvalumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	_	10/10/2021
J9176		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
	Inj Enfort Vedo-Ejfv	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A		Admired to DA list	
J9177	0.25Mg Gemtuzumab	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may		#N/A	Moved to PA list	10/10/2021
J9203	Ozogamicin 0.1 Mg	require Prior Authorization per contract agreement.	#N/A	#N/A	-	-
J9204	Inj Mogamulizumab- Kpkc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9205	Inj Irinotecan Liposome 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	_	10/10/2021
J9219	Leuprolide Acetate Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	Moved to PA list	12/31/2021
J9223	Inj. Lurbinectedin 0.1	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	10/10/2021
J9225	Mg Vantas Implant	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX502.061	Oncology Medications	Moved to PA list	12/31/2021
J9226		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.041			
	Supprelin La Implant Inj. Isatuximab-Irfc 10	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists		12/31/2021
J9227	Mg	predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9228	Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
J9229	Inj Inotuzumab Ozogam 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	-
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
19271	Mcg Inj Pembrolizumab	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
J9281	Mitomycin Instillation	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	#N/A	#N/A	Moved to PA list	10/10/2021
J9285	Inj Olaratumab 10 Mg	service review.	-	-	5/15/2021	-
J9295	1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9299	Injection Nivolumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
J9301	Obinutuzumab Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	_	10/10/2021
J9306	•	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A		10/10/2021
19308	Mg Injection Ramucirumab	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	*N/A		10/10/2021
	Inj Polatuzumab	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-0, 10, 2021
J9309	Vedotin 1Mg Inj Rituximab	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	#N/A	#N/A	Moved to PA list	-
J9311	Hyaluronidase	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9312	Inj. Rituximab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	-	12/31/2021
J9313	Inj. Lumoxiti 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	-
	Injection, Pertuzumab,	AND Calendar Described for the state of the				
J9316		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
	10 Mg					
J9317	Hziy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
J9325	Inj Talimogene Laherparepvec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	12/31/2021
J9349	Injection, Tafasitamab-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	_
	Cxix, 2Mg Injection Trabectedin	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				
J9352	0.1Mg	require Prior Authorization per contract agreement.	#N/A	#N/A	-	-

J9354	Inj Ado-Trastuzumab Emt 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
J9358		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	#N/A	#N/A	Moved to PA list	10/10/2021
J9600	1Mg Porfimer Sodium	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.029			., .,
13000	Injection	predetermination to avoid post-service review.	MED203.002	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus	-	-
19999	Chemotherapy Drug	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. May require PA per contract agreement.	RX501.063 RX501.087 RX501.085 RX501.057	-	-	-
кооо5	Ultralightweight	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0010	Wheelchair Stnd Wt Frame Power	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
	Whichr Stnd Wt Pwr Whichr W	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0011	Control Ltwt Portbl Power	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0012	Whichr	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0013	Custom Power Whichr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0014	Other Power Whichr Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0053	Elevate Footrest Articulate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0065	Spoke Protectors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
	W/C Component	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Criteria.			_	_
K0108	W/C Component- Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	-	-
K0455	Pump Uninterrupted	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	_
к0800		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0801	300Lbs Pov Group 1 Hd 301-450	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
	Lbs Pov Group 1 Vhd 451-	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0802	600 Lbs	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0806	Pov Group 2 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0807	Pov Group 2 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
K0808	Pov Group 2 Vhd 451- 600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
W0040	Power Operated Vehicle	MP Criteria: Procedure/service reviewed against Medical Criteria.				
K0812	Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	-	-
K0813	Pwc Gp 1 Std Port Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0814	Pwc Gp 1 Std Port Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0815	Pwc Gp 1 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0816	Pwc Gp 1 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	_	_
	Pwc Gp 2 Std Port	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0820	Seat/Back Pwc Gp 2 Std Port Cap	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0821	Chair	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0822	Pwc Gp 2 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	-	-
K0823	Pwc Gp 2 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	_	-
K0824	Pwc Gp 2 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	_	_
K0825	Pwc Gp 2 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0826	Pwc Gp 2 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		
K0827		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
	Pwc Gp Vhd Cap Chair Pwc Gp 2 Xtra Hd	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0828	Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0829	Pwc Gp 2 Xtra Hd Cap Chair	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0830	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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0836	Pwc Gp2 Std Sing Pow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0837	Opt Cap Pwc Gp 2 Hd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
	Opt S/B Pwc Gp 2 Hd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0838	Opt Cap Pwc Gp2 Vhd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0839	Opt S/B	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0840	Pwc Gp2 Xhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0841	Pwc Gp2 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	_	-
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	_	_
K0843	Pwc Gp2 Hd Mult Pow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0848	Opt S/B Pwc Gp 3 Std Seat/Back	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0849	Pwc Gp 3 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	-	-
K0850	Pwc Gp 3 Hd Seat/Back	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0851	Pwc Gp 3 Hd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0852	Pwc Gp 3 Vhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0853	Pwc Gp 3 Vhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
		•				

K0854	Pwc Gp 3 Xhd Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF101.010	Wheelchairs and Accessories		
K0855	Pwc Gp 3 Xhd Cap Chair	mP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0856	Pwc Gp3 Std Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0857	Opt S/B Pwc Gp3 Std Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
	Opt Cap Pwc Gp3 Hd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0858	Opt S/B Pwc Gp3 Hd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0859	Opt Cap Pwc Gp3 Vhd Sing Pow	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0860	Opt S/B	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0861		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0862		mediate in the avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0863		predetermination to avoid post-service reviewed against inedical Policy Criteria. Submit for MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	-	-
K0864	Opt S/B	predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0868	Pwc Gp 4 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0869	Pwc Gp 4 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0870	Pwc Gp 4 Hd Seat/Back	MP Criteria: Procedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0871	Pwc Gp 4 Vhd Seat/Back	predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0877	Pwc Gp4 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0878	Pwc Gp4 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Wheelchairs and Accessories	-	-
K0879	Pwc Gp4 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
K0880		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0884			DME101.010	Wheelchairs and Accessories	_	_
K0885			DME101.010	Wheelchairs and Accessories	_	_
K0886	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	_	_
K0890	Pwc Gp5 Ped Sing Pow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		_
K0891	Pwc Gp5 Ped Mult Pow	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories		
K0898	Opt S/B Power Wheelchair Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
K0899	Pow Mobil Dev No	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF101 010	- Wheelchairs and Accessories	-	-
	Dmepdac Ces System W/Supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		WINCELLIBITS BITA ACCESSORIES	-	_
K1002	Access	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	-	-
K1003	Whirlpool Tub Walkin Portabl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
K1004	Lo Freq Us Diathermy Device	EIU: Procedure/service 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	_	_
	Bil Hkaf Pc S/D Micro	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
K1007	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	_
K1023	Trans elec nerv periph	Policy (CPCP). 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
	nerv Trans elec nerv periph	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				,,
K1023	nerv	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	1/1/2022	-
K1024	Non pneum comp control cal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	10/1/2021	12/31/2021
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	1/1/2022	_
K1025	Non pneum compress	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
	full arm Non pneum compress	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	ADIVI1001.032			
K1025	full arm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		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	-
L0999	Add To Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
L1499	Spinal Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
L1834	Ko W/O Joint Rigid Molded To	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	_	_
L1840	Ko Derot Ant Cruciate Custom	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIVIE 103.002	Knee Braces	_	-
L1844	Ko W/Adj Jt Rot Cntrl Molded	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.002	Knee Braces	_	_
L1846		Annah and a district and a second and a second	DME103.002	Knee Braces	_	_
L2006	Kaf Sng/Dbl Swg/Stn Mcpr Cus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
L2999	Lower Extremity Orthosis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
L3040	Ft Arch Suprt Premold Longit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_		_	_
L3050		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-		_	_	_
L3050		senice review	-			
L3060	Metat Foot Arch Supp	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		_	_
	Metat Foot Arch Supp Longitud/Meta Orthopedic Shoe	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	-	_	-	_
L3060	Metat Foot Arch Supp Longitud/Meta	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	_
L5981	Flex Flex-Walk Sys Low Ext	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104 012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	
	Prosth	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to		tower-timb Prostnetics, including with oprocessor-controlled Prostnetics	-	-
L5999	Nos	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	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		
10021	Friction	predetermination to avoid post-service review.	DIVICIO4:001	Prosthesis	-	-
	Electric Hand Switch Or Myolelectric Controlled					
	Independently					
L6880	Articulating Digits Any Grasp Pattern Or	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	-	-
	Combination Of Grasp Patterns Includes					
	Motor(S)					
L6882		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		
1.0020	Uplmb Wrist Disarticul Switch	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	-	_
L6920	Ctrl	predetermination to avoid post-service review.	DIVIE104.001	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	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		_
	Myoelectronic Ct	predetermination to avoid post-service review. MR Citation Proceedings (see in a surject of Administration Policy Citation Culture)		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	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		
	Myoelectronic C Above Elbow Switch	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DIVIE104.001	Prosthesis Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb	-	-
L6950	Control	predetermination to avoid post-service review.	DIVIE104.001	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	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	_	_
	Contro Shldr Disartic	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	-	_
L6965	Myoelectronic Interscapular-Thor	predetermination to avoid post-service review. MD Criteria Precedure (spring reviewed against Medical Policy Criteria, Submit for		Prosthesis Unper Limb Prosthesis Including Muscleatric and Orthodic Components, and Other Prosthetics Event for Lower Limb	-	-
L6970	Switch Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L6975	Interscap-Thor Myoelectronic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L7007	Adult Electric Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	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	-	-
L7008	Pediatric Electric Hand	predetermination to avoid post-service review.	DIVIE104.001	Prosthesis	-	-
L7009	Adult Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7040	Prehensile Actuator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L7045	Pediatric Electric Hook	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb		
L7170	Electronic Elbow	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	-	_
L/1/0	Hosmer Swit Electronic Elbow	predetermination to avoid post-service review.	DIVIE104.001	Prosthesis	-	-
L7180	Sequential	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7181	Electronic Elbo Simultaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L7185	Electron Elbow	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		
	Adolescent Sw Electron Elbow Child	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	-	-
L7186	Switch	predetermination to avoid post-service review.	DIVIE104.001	Prosthesis	-	-
L7190	Elbow Adolescent Myoelectron	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DIVIE104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7191	Elbow Child Myoelectronic Ct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	_	_
L7259	Electronic Wrist Rotator	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		
	Any Twelve Volt Battery	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	-	-
L7364	Utah/Equ Battery Chrgr 12 Volt	predetermination to avoid post-service review.	DME104.001	Prosthesis	-	-
L7366	Utah/E	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis	-	-
L7499	Upper Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
L8039	Breast Prosthesis Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Unspec Maxillofacial	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
L8048	Prosth	contract/clinical review.	-	-	-	-
L8499	Ser	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
L8604	Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	_	_
10005	Inj Bulking Agent Anal	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
L8605	Canal	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	5UK/10.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	-	-
L8606	Synthetic Implnt Urinary 1MI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.008 SUR710.022	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	_	_
	Arg Ii Ext Com/Sup/Acc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
L8608	Misc Misc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	-	-
L8612	Aqueous Shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma		
	Prosthesis Cocklear Daviso	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			-	
L8614	Cochlear Device Coch Implant Headset	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant	-	-
L8615	Replace	require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8616	Coch Implant Microphone Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	_
L8617	Coch Implant Trans Coil	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant	_	_
L8618		require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant		
20010	Repl	require Prior Authorization per contract agreement.	201724.004		-	-

L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	_	_
L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	_	_
L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant		
	Lith Ion Batt Cid Non-	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may			-	-
L8623	Earlvl	require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	-	-
L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.004	Cochlear Implant	_	_
L8628	Cid Ext Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant		
	Cid Transmit Coil And	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may				_
L8629	Cable Aud Osseo Dev Int/Ext	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	SUR714.004	Cochlear Implant	-	-
L8690	Comp	require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
L8691	Aoi Snd Proc Repl Excl Actua	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
L8693	Aud Osseo Dev Abutment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
L8694	Repl	predetermination to avoid post-service review.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	-	-
L8699	Prosthetic Implant Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	- -	_	_
L8701	Ewh S/D Uprt Micro	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		
L8702	Sensor Ewhf S/D Uprt Micro	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	-	-
18702	Sensor	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	DME104.001	Prosthesis	-	-
M0075	Cellular Therapy	service review.	-	-	-	-
P2031	Hair Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	_	_
P9020	Diselet Dieb Disesse Heit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	RX501.101	Orthopedic Applications of Platelet-Rich Plasma		
F3020	Plaelet Rich Plasma Unit	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
P9099	Blood Component/Product	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.			_	
	Noc	Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
Q0507	Misc Sup/Acc Ext Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
Q0508	Misc Sup/Acc Imp Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
Q0509	Mis Sup/Ac Imp Vad	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
Q0510	Nopay Med Dispens Fee	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
	Immunosupressive Sup Fee Antiem Antica	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
Q0511	Immuno	service review.	-	-	-	-
Q0512	Px Sup Fee Anti-Can Sub Pres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
Q2026	Radiesse Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
Q2028	Inj Sculptra 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
Q2039	Nos	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	-	-	-	-
Q2041	Car+	require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	-
Q2042	Tisagenlecleucel Car-Pos T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	-
Q2043	Sipuleucel-T Minimum Of 50 Million Autologous Cd54+ Cells Activated With Pap-Gm- Csf Including Leukapheresis And All Other Preparatory Procedures Per Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	#N/A	#N/A	-	10/10/2021
Q2050	Doxorubicin Inj 10Mg	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. May require PA per contract agreement.	-		-	_
Q2052	Ivig Demo Services/Supplies	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
Q2053	Brexucabtagene Autoleucel, Up To 200 Million Autologous Anti- Cd19 Car Positive Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	4/1/2021	-
	Lisocahtagene mara car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
Q2054	pos t	predetermination to avoid post-service review.	KA302.001	Oncology Medications	10/1/2021	-
Q2055	Idecabtagene Vicleucel Car	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	1/1/2022	-
Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
Q4051	Splint Supplies Misc	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-			
Q4082	Drug/Bio Noc Part B Drug Cap	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
		MP Criteria: Procedure/service reviewed against Medical Criteria.				
Q4100	Skin Substitute Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.		Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4101	Apligraf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_
Q4102	Oasis Wound Matrix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	_
		predetermination to avoid post-service review.				

Q4103	Oasis Burn Matrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4104	Integra Bmwd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4105	Integra Drt Or Omnigraft	predetermination to avoid post-service review.	5UR7U4.U12	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4106	Dermagraft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. 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	SUR/04.012	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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4111	Gammagraft	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	-
Q4112	Cymetra Injectable	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	-
Q4113	Graftjacket Xpress	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4114	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).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4116	Alloderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4118	Matristem Micromatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4121	Theraskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4122	Dermacell Awm Porous Sq Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	10/15/2021	-
Q4122	Dermacell Awm Porous Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	10/14/2021
Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4125	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4126	Memoderm/Derma/Tran z/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).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4128	Flexhd/Allopatchhd/Mat rixhd	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).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4132	Grafix core grafixpl core			Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4133	Grafix stravix prime pl sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4134	Hmatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4135	Mediskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4136	Ezderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4137	Amnioexcel Biodexcel 1Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4138	Biodfence Dryflex 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4139	Amnio Or Biodmatrix Inj 1Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4140	Biodfence 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4141	Alloskin Ac 1 Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4142	Xcm Biologic Tiss Matrix 1Cm	FILL Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4143	Repriza 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4145	Epifix Inj 1Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4146	Tensix 1Cm	Fills: Procedure/service not reimbursed 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	Bloengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4147	Architect Ecm Px Fx 1 Sq Cm	FILL Draggedure (consists not reimburged by the Dlan Not subject to are consists	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
		, va. 61 j.				

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 SUR Policy (CPCP).	704.011	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 SUR Policy (CPCP).	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4150	Allowrap Ds Or Dry 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	-	-
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. ${\sf SUR}$	704.011	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 SUR Policy (CPCP).	704.012	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 SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4154	Biovance 1 square cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4155	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4156	Neox 100 Or Clarix 100	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4157	Revitalon 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 SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4158	Kerecis Omega3 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 SUR Policy (CPCP).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4159	Affinity1 Square Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	704.011	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 SUR Policy (CPCP).	704.011	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 SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4161	Bio-Connekt Per Square Cm	FILL Procedure/service not reimbursed by the Plan. Not subject to pre-service	704.012	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 SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4163	Woundex Bioskin Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4164	Helicoll 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 SUR Policy (CPCP).	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4165	Keramatrix Kerasorb Sq Cm	FILL Procedure/service not reimbursed by the Plan. Not subject to pre-service	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4166	Cytal 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 SUR Policy (CPCP).	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4167	Truskin 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 SUR Policy (CPC).		Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4168	Amnioband 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4169	Artacent Wound Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4170	Cygnus Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4171	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4173	Palingen Or Palingen Xplus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4174	Palingen Or Promatrx	Folicy (PCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4175	Miroderm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR	704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	-
Q4176	Neopatch Or Therion, 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 SUR Policy (CPCP).	704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4177		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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4178	Floweramniopatch 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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4179		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 SUR	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4180	Revita 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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4181	Amnio Wound Per Square 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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4182	Transcyte 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 SUR	704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4183	Surgigraft 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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4184	Cellesta Or Duo Per Sq Cm	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR	704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4185	Cellesta Flowab Amnion 0.5Cc	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 SUR	704.011	Amniotic Membrane and Amniotic Fluid	_	_
	U.SCC	Policy (CPCP).				

Company	Q4186	Epifix 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	
Part			predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for CLIPZOA 011			-
		,	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		14, 15, 1111	-
Part			Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service		-	-
Section Sect	Q4103	Artacent Ac 1 Mg	Policy (CPCP).	Anniotic Membrane and Anniotic Find	-	-
Section Sect	Q4190	Artacent Ac 1 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	-	-
Marie Mari	Q4191	Restorigin 1 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	-	-
Section Sect	Q4192	Restorigin 1 Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding $$ SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Section Sect	Q4193	Coll-E-Derm 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012 Policy (CPCP).	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Note 1967	Q4194	Novachor 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Section Page	Q4195	Puraply 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Page	Q4196	Puraply Am 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
March Marc	Q4197	Puraply Xt 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
March Section March Ma	Q4198		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
March 1, 1972 March 1, 197	Q4200	Skin Te 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012 Policy (CPCP).	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Part	Q4201	Matrion 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
December	Q4202	Keroxx (2.5G/Cc) 1Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012 Policy (CPCP).	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
	Q4203	Derma-Gide 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding $$ SUR704.012 Policy (CPCP).	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Member Member Perkey Member Perkey Member M	Q4204	Xwrap 1 Sq Cm	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Part	Q4205		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Rough for Sq. Rough for Sq	Q4206		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Sugart For Sug Support For Sug Support For Sug Support For Sug Support Sug	Q4208	Novafix 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	-	-
Amount of Clark	Q4209	Surgraft 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	-	-
Amminist Note Not Note Note Note Note Note Note Note Note Note	Q4210		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding $$ SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Amoint Membrane and Amniotic Fluid Membrane and Amniotic	Q4211		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
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Part	Q4213	Ascent 0.5 Mg	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
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Author Policy (PCP) Policy (PCPO) Poli	Q4216	Artacent Cord Per Sq Cn	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Surgigraft Dual Per Sq Cm Policy (CPCP). Surgigraft Dual Per Sq Cm Cm Policy (CPCP). Surgigraft Dual Per Sq Cm Policy (CPCP). ELL' Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). ELL' Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). ELL' Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). ELL' Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). ELL' Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP0. ELU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP0. ELU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP08. ELU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Policy CPCP08. ELU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Payment and Coding Policy CPCP08. ELU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check ELU policy CPCP08, which is one of our Clinical Payment and Coding Payment and Co	Q4217		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
Q4219 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4220 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q421 Amniowap2 Per SQ CPCP0. Q4221 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4222 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4223 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4224 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4225 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4226 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4227 Procedure/Service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP0. Q4228 Bionestpatch Per Sq Cm review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding CPCP08. Q4228 Amniotic Membrane and Amniotic Fluid Q4229 Amniotic Membrane and Amniotic Fluid	Q4218	Surgicord 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	-	-
G4222 Progenamatrix Per Sq Cm Procedure/service not reimbursed by the Plan. Not subject to pre-service Cm/service. Check EIU policy (CPCP)8, which is one of our Clinical Payment and Coding Payment and Coding Procedure/service not reimbursed by the Plan. Not subject to pre-service Cm/service. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Payment and Coding Procedure/service not reimbursed by the Plan. Not subject to pre-service Cm/service. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Payment and Coding Payment and Coding Procedure/service not reimbursed by the Plan. Not subject to pre-service Cm/service. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Payment and Coding Payment and Coding Pain Pain Pain Pain Pain Pain Pain Pain	Q4219		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Policy (CPCP).	Amniotic Membrane and Amniotic Fluid	-	-
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Q4222 Progenitation Per Sq Progedure/Service not reimbursed by the Plan. Not subject to pre-service Substitutes Substitu	Q4221	Amniowrap2 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	-	-
Q4227 Amniocore Per Sq Cm review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Sun Policy (CPCP). EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service Q4228 Bionextpatch Per Sq Cm review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Surprise and Amniotic Fluid	Q4222		review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.012 Policy (CPCP).	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4228 Bionextpatch Per Sq Cm review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011 Amniotic Membrane and Amniotic Fluid	Q4227	Amniocore Per Sq Cm	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	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-

Q4229	Cogenex Amnio Memb Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4230	Cogenex Flow Amnion 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4231	Corplex P Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4232	Corplex 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	-	-
Q4233	Surfactor /Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4234	Xcellerate Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4235	Amniorepair Or Altiply Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4236	Carepatch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4237	Cryo-Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	-	-
Q4238	Derm-maxx, per sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	02.01/2022	6/30/2022
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
Q4238	Derm-maxx, per sq cm Amnio-Maxx Or Lite Per	review. Check EIU policy CPCP028, 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	7/1/2022	-
Q4239	Sq Cm Corecyte Topical Only	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	-	-
Q4240	0.5 Cc	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	-	-
Q4241	Polycyte Topical Only 0.5Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4242	Amniocyte Plus Per 0.5 Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4244	Procenta Per 200 Mg	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	-	-
Q4245	Amniotext Per Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4246	Coretext Or Protext Per Cc	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4247	Amniotext Patch Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4248	Dermacyte Amn Mem Allo Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4249	Amniply Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4250	Amnioamp-Mp Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4251	Vim per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4252	Vendaje per square	$\label{eq:mpcond} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for } \mbox{\cite{MP Criteria: Procedure/service reviewed against Medical Policy Criteria.} \mbox{\cite{MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medical Policy Criteria.} \cite{MP Criteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed ag$	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	12/31/2021
Q4252	vendaje per square centimet	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR704.011	Amniotic Membrane and Amniotic Fluid	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 review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4254	Novafix DI Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4255	Reguard Topical Use Per Sq	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q5009 Q5103	Hospice Care Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	- RX501.051	- Infliximab and Associated Biosimilars	-	-
	Injection Inflectra	require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	RX501.096 RX501.051	Specialty Medication Administration Site of Care Infliximab and Associated Biosimilars	-	-
Q5104	Injection Renflexis	require Prior Authorization per contract agreement.	RX501.051 RX501.096	Infliximate and Associated Biosimilars Specialty Medication Administration Site of Care	-	-
Q5106	Inj Retacrit Non-Esrd Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	-
Q5107	Inj Mvasi 10 Mg	$\label{eq:MPCriteria:Procedure/service} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for } \mbox{\cite{MPCriteria: Procedure/service reviewed against Medical Policy Criteria.} \cite{MPCRiteria: Procedure/service reviewed against Medical Policy Criteria: Procedure/service reviewed against Medical Policy Cri$	#N/A	#N/A	Moved to PA list	10/10/2021
Q5109	Injection Ixifi 10 Mg	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.051	Infliximab and Associated Biosimilars	-	-
Q5115	Inj Truxima 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	-	-
Q5118	Inj. Zirabev 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
Q5119	Inj Ruxience 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	#N/A	#N/A	Moved to PA list	10/10/2021
S0013	Esketamine Nasal Spray	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.105	Esketamine Nasal Spray	2/1/2021	-
S0117	Tretinoin Topical 5 G	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
S0142	Colistimethate Inh Sol Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-

S0157	Becaplermin Gel 1% 0.5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions	-	-
S0189	Testosterone Pellet 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 RX501.007 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Tested toping Beautement Therapies	-	-
S0197	Prenatal Vitamins 30 Day	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	Testosterone Replacement Therapies	-	_
S0310	Hospitalist Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S0320	Rn Telephone Calls To Dmp	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	_	-	_	_
S0590	Misc Integral Lens Serv	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	_	_
S0622	Phys Exam For College	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S0800	Laser In Situ	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUP712 001	Refractive and Therapeutic Keratoplasty		
	Keratomileusis Photorefractive	predetermination to avoid post-service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	301713.001	nerocive and Therapeutic Keratopiosty	-	-
S0810	Keratectomy	service review.	-	-	-	-
S1001	Deluxe Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S1002	Custom Item	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
S1040	Cranial Remolding	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME103.007	Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses		
	Orthosis Stent Non-Coronary	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
S1091	Propel	predetermination to avoid post-service review.	SUR706.001	Nasal and Sinus Surgery	5/15/2021	-
S2083	Adjustment Gastric Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	-
S2117	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	-	-
S2118	Total Hip Resurfacing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.019	Hip Resurfacing (HR)	_	_
S2120	Low Density	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may	THE802.003	Lipid Apheresis	_	_
	Lipoprotein(LdI)	require Prior Authorization per contract agreement.				
52140	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 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.039 SUR703.034 SUR703.034 SUR703.034 SUR703.035 SUR703.036 SUR703.044 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 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 Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Hodgkin Lymphoma (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 Plasma Cell Dyscrasias, Including Multiple Myeloma (Ell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gwaldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gwaldenstrom Germ Cell Tumors	-	-
52142	Cord Blood-Derived Stem-Cell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.043 SUR703.036 SUR703.036 SUR703.039 SUR703.029 SUR703.029 SUR703.041 SUR703.040 SUR703.040 SUR703.040 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 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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Horioric Myeloid Leukemia 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 Paisma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Paisma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Paisma Cell Dyscrasias, Including Multiple Myeloma (MT) Hematopoietic Cell Transplantation for Paisma Cell Dyscrasias, Including Multiple Myeloma (MT) Hematopoietic Cell Transplantation for Paisma Cell Dyscrasias, Including Multiple Myeloma (MT) Hematopoietic Cell Transplantation for Paisma Cell Dyscrasias, Including Multiple Myeloma (MT) Hematopoietic Cell Transplantation for Gelman Systemic Amyloidosis Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Gelman Systemic Amyloidosis	-	-

\$2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.043 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.039 SUR703.034 SUR703.035 SUR703.040 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 Autoimmune Diseases Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Centrolic Lymphocytic Leukemia (LLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (LLL) 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 Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for 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 Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Formace Mematopoietic Cell Transplantation for Genetic Malensense Mossile Hematopoietic Cell Transplantation for Malensens	-	-
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	301707.010	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.		Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	-	-
S2235	Implant Auditory Brain Imp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR714.009	Auditory Brainstem Implant	_	_
S2300	Arthroscopy Shoulder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	SUR705.041	Thermal Capsulorrhaphy as a Treatment of Joint Instability		
	Surgi	Policy (CPCP). Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	_
S2409	Fetal Surg Noc	contract/clinical review.	-	-	-	-
\$2900	Surgical Techniques Requiring Use Of Robotic Surgical System (List Separately In Addition To Code For Primary Procedure)	predetermination to avoid post-service review.	SUR701.014	Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery	-	-
S3600	Stat Lab	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S3601	Stat Lab Home/Nf	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S3650	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	-	-
	Saliva Test Hormone Level;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.128	Salivary Hormone Testing	-	-
S3900	Surface Emg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy	-	-
S4015	Rate	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S4023	Incompl Donor Egg Case Rate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Services for Infertility and Recurrent Fetal Loss	-	-
S4025	Donor Serv lvf Case Rate			Services for Infertility and Recurrent Fetal Loss	-	-
S4026		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Services for Infertility and Recurrent Fetal Loss	-	-
S4027	Store Prev Froz Embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.		Services for Infertility and Recurrent Fetal Loss	-	_
S4030	Sperm Procure Init Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
S4031	Sperm Procure Subs Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	UB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
S4040	Monit Store Cryo Embryo 30 D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	_	_
S4990	Nicotine Patch Legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	<u> </u>	-	_
S4991	Nicotine Patch Nonlegend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S4995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S5035	Hit Routine Device Maint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S5036	Hit Device Repair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5100	Adult Daycare Services	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5101		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-	_	_	_	_
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_		_	_
S5109	Homecare Train Pt Session	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5110	Family Homecare Training 15M	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S5111	Family Homecare Train/Sessio	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
S5115	Nonfamily Homecare Train/15M	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	_
S5116	Nonfamily Hc Train/Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_		_	_
S5120	Chore Services Per 15 Min	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_		_	_
S5121	Chore Services Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	-	_	_
S5125	Attendant Care Service /15M		_	-	_	_
	,					

S5126	Attendant Care Service /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5130	Homaker Service Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.				
	Per 15M	Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
S5131	Homemaker Service Nos /Diem	service review.	_	-	_	_
	Adult Companioncare	Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S5135	Per 15M	service review.	-	-	-	-
S5136	Adult Companioncare	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
33130	Per Diem	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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S5151	/15M Unskilled Respitecare	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			_	
	/Diem Emer Response Sys	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
S5160	Instal&Tst Emer Rspns Sys Serv	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S5161	Permonth	service review.	-	-	-	-
S5162	Emer Rspns System Purchase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S5165	Home Modifications Per Serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S5170	Homedelivered Prepared Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S5175	Laundry Serv Ext Prof	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_	_	_	_
S5181	/Order Hh Respiratory Thrpy	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
S5185	Nos/Day Med Reminder Serv Per	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	_
33103	Month	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S5199	Personal Care Item Nos Each	service review. Unlisted: Procedure/service not specifically defined or classified	-	-	-	-
S5497	Hit Cath Care Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
S8035	Magnetic Source	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
36033	Imaging	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	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	-	-
	Interferential Current	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service				
S8131	Stimulator 4 Channel	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	-	-
S8189	Trach Supply Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
S8270	Enuresis Alarm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S8301		Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
S8460	Nos Camisole Post-Mast	contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
	Auricular	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
S8930	Electrostimulation	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	-	-
S8940	Hippotherapy Per Session	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	THE803.022	Hippotherapy	-	_
		Policy (CPCP).	THE801.028	Acne Management		
S8948	Low-Level Laser Trmt 15 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR702.005 MED201.045	Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence Low-Level and High-Power Laser Therapy	_	_
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	MED205.022	Treatment of Tinnitus		
S8990	Pt Or Manip For Maint	service review.	-	-	-	-
S9001	Home Uterine Monitor With Or	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding	OB401.017	Home Uterine Activity Monitoring	_	_
		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 Policy (CPCP).	MED205.014	Sensory Stimulation for Coma Patients	-	-
S9090	Vertebral Axial	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	THEOD3 034	Non-Surgical Spinal Decompression Traction Devices		
35050	Decompressio	review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).		non-surgical spillal decompression fraction devices	-	-
S9117	Back School Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.024	Back School	-	-
S9125	Respite Care In The Home P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S9335	Ht Hemodialysis Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE802.002	Daily Hemodialysis and Hemodialysis in the Home Setting	_	_
S9379	Hit Noc Per Diem	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to			_	
S9381	Hit High Risk/Escort	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-	-	-	-	-
S9436	Lamaze Class Childbirth Refresher	Service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	•	-	-
S9437	Class	service review.	-	-	-	-
S9438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S9439	Vbac Class	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	-	-	-	-
S9442	Birthing Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9444	Parenting Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
S9445	Pt Education Noc Individ	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to				
		contract/clinical review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_			-
S9446	Pt Education Noc Group		-	-	-	-

S9447	Infant Safety Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S9449	Weight Mgmt Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	_	_	_
S9451	Exercise Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-		-	_
S9454	Stress Mgmt Class Cardiac Rehabilitation	service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
S9472	Progr	predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	-	-
S9482	Family Stabilization 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	_
S9542	Ht Inj Noc Per Diem	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
S9558	Ht Inj Growth Horm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.040	Human Growth Hormone (GH)		
	Diem	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
S9562	Ht Inj Palivizumab Diem	predetermination to avoid post-service review.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	-	-
S9810	Ht Pharm Per Hour	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	-
S9900	Christian Sci Pract Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9970	Health Club	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
S9975		service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Diem	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9976	Lodging Per Diem	service review.	SUR703.001	-	-	-
		Unlisted: Procedure/service not specifically defined or classified Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
S9977	Meals Per Diem	service review. Unlisted: Procedure/service not specifically defined or classified	SUR703.001	-	-	-
S9981	Med Record Copy Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	_
S9982	Med Record Copy Per	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	Page Not Medically Necessary	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9986	Svc	service review.	-	-	-	-
S9988	Serv Part Of Phase I Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S9990	Services Provided As Part Of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	_	_
S9991	Services Provided As	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	_		_	
S9992	Part Of Transportation Costs To	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
	And Lodging Costs (E.G.	service review. Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	-	-	-	-
S9994	Hotel Ch	service review.	-	-	-	-
S9996	Meals For Clinical Trial Par	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
S9999	Sales Tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	- -	_	_
T1014		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-			1/1/2021	
T1505	Min Elec Med Comp Dev	service review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-			_
	Noc Retail Items	contract/clinical review.	-	-	-	-
T1999	Noc Retail Items Andsupplies	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	- -	-	-
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T2040	Financial Mgt Waiver/15Min	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	-	_	_
T2041	Support Broker	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
12041	Waiver/15 Min	contract/clinical review.	-	-	-	-
T2101	Breast Milk Proc/Store/Dist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	_	-	-	_
T5999	Supply Nos	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-	-	-	-	_
V2025	Eyeglasses Delux Frames	service review.	-	-	-	-
V2199	Lens Single Vision Not	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
	Oth C Contact Lens/Es Other	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
V2599	Type	contract/clinical review.	-	-	-	-
V2629	Prosthetic Eye Other Type	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-				
V2/02		service review.	-	-	-	-
V2744	Tint Photochromatic Lens/Es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	-	-	-	-
V2787	Astigmatism-Correct	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_
142700	Function Presbyopia-Correct	predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
V2788	Function	predetermination to avoid post-service review.	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	-	-
V2799	Misc Vision Item Or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre- service review.	OTH903.012			
*2733	Service	Unlisted: Procedure/service not specifically defined or classified	DME104.003	-	-	-
V5090		Unlisted: Procedure/service not specifically defined or classified, may be subject to	_		_	_
	Fee Implant Mid Ear Hearing	contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
V5095	Pros	predetermination to avoid post-service review.	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	-	-
V5267	Hearing Aid Sup/Access/Dev	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	_	_	_	_
V/5274		Unlisted: Procedure/service not specifically defined or classified, may be subject to				
V5274	Ald Unspecified	contract/clinical review.	-	-	-	-
V5287	Ald Fm/Dm Receiver Nos	Unlisted: Procedure/service not specifically defined or classified, may be subject to contract/clinical review.	-	-	-	_
V5298	Hearing Aid Noc	Unlisted: Procedure/service not specifically defined or classified, may be subject to				
. 3230		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, may be subject to	-	-	_	_
V5299	Hearing Service	contract/clinical review.	-	-	-	-
V5362	Speech Screening	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)	_	_
		predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
V5363	Language Screening	predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	-	-