

## **Medical Policy Reference List (Commercial)**

2021 Benefit Procedure Code List

**Updated November 2021** 

## EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN, THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1, 2021.

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.

For information on how to submit a voluntary predetermination request, refer to our Utilization Management section on our website at https://www.bcbsil.com/provider/claims/um.html. Predetermination requests may be submitted via the Availity® Provider Portal (availity.com) using the Availity Attachments tool.

This information is not applicable to services provided to any of our HMO or government programs members.

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP	Procedures/services reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.
Criteria)	Highlighted procedures/services 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 CPCP028, 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. (codes in RED text)

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Code	Code Description	Code Group & Description	Policy No.	Medical Policy Title	Effective Date	Ending Date
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	-	_
07957	Weight Loss	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	9/30/2021
11920	Correct Skin Color 6.0 Cm/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive and Contralateral Mammaplasty	_	_
11921	Correct Skn Color 6.1-20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive and Contralateral Mammaplasty	-	_
11922	Correct Skin Color Ea 20.0Cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures Reconstructive and Contralateral Mammaplasty	-	_
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 Biosoffers: 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 Biosoffers's 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 Biosoffers's Surgical Management	-	-
11960	Insert Tissue Expander(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
11970	Rplcmt Tiss Xpndr Perm Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR716.001 SUR716.011	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures Reconstructive 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	-	-

11981	Insert Drug Implant Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 RX501.007 RX501.076 RX501.082	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 Treatment of Opioid Dependence	-	-
11983	Remove/Insert Drug Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 RX501.007 RX501.076 RX501.082	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 Treatment of Opioid Dependence	-	-
15734	Muscle-Skin Graft Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Reconstructive and Contralateral Mammaplasty	-	_
15758	Free Fascial Flap Microvasc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.024	Surgery for Lipedema and Lymphedema	-	-
15769	Grfg Autol Soft Tiss Dir Exc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Reconstructive Breast Surgery	1/15/2021	_
15771	Grfg Autol Fat Lipo 50 Cc/<	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.021 SUR716.011	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast	1/15/2021	_
15772	Grfg Autol Fat Lipo Ea Addl	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.021	Reconstructive Breast Surgery Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast	1/15/2021	
15775	Hair Trnspl 1-15 Punch Grfts	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011 SUR716.001	Reconstructive Breast Surgery  Cosmetic and Reconstructive Procedures		
15776	Hair Trnspl >15 Punch Grafts	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review.	THE801.028	Acne Management		
15780	Dermabrasion Total Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 THE801.030 THE801.028	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea Acne Management	-	-
15781	Dermabrasion Segmental Face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 THE801.030	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
45703	Daniel and a Other Theory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
15782	Dermabrasion Other Than Face	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures		
15783	Dermabrasion Suprfl Any Site	predetermination to avoid post-service review.	SUR717.001 THE801.030	Cosmient and Reconstructive Proceedings Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028	Acne Management		
15786	Abrasion Lesion Single	predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
15787	Abrasion Lesions Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028 SUR716.001	Acne Management Cosmetic and Reconstructive Procedures	_	_
		predetermination to avoid post-service review.	SUR717.001 THE801.028	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Acne Management		
15788	Chemical Peel Face Epiderm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.018 SUR717.001	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
			THE801.030 THE801.028	Nonpharmacologic Treatment of Rosacea Acne Management		
15789	Chemical Peel Face Dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.018	Chemical Peels	_	_
		predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea		_
15792	Chemical Peel Nonfacial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.018	Acne Management Chemical Peels		
13732	Chemical Feet Homacia	predetermination to avoid post-service review.	SUR717.001 THE801.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR716.018	Acne Management Chemical Peels		
15793	Chemical Peel Nonfacial	predetermination to avoid post-service review.	SUR717.001 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 predetermination to avoid post-service review.	SUR716.004 SUR717.001	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
15821	Revision Of Lower Eyelid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair		
15822	Revision Of Upper Eyelid	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair		
15823	Revision Of Upper Eyelid	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Blepharoplasty, Blepharoptosis and Brow Repair		
	nevision of opper Eyenu	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001 SUR716.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Cosmetic and Reconstructive Procedures		
15824	Removal Of Forehead Wrinkles	Prior Authorization per contract agreement.	SUR717.001 SUR712.031	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Sites	-	-
15825	Removal Of Neck Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
15826	Removal Of Brow Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
13820	Removal of Blow Willkies	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR712.031 SUR716.001	Surgical Deactivation of Headache Trigger Sites  Cosmetic and Reconstructive Procedures	-	-
15828	Removal Of Face Wrinkles	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
15829	Removal Of Skin Wrinkles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	<u> </u>
15830	Exc Skin Abd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024 SUR716.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures		
15832	Excise Excessive Skin Thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema		
15833	Excise Excessive Skin Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15834	Excise Excessive Skin Hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15935	Excise Excessive Skin Buttck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024 SUR716.001	Cosmetic and Reconstructive Procedures		
15835	EXCISE EXCESSIVE SKIN BUTTCK	predetermination to avoid post-service review.	SUR717.001 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	
15836	Excise Excessive Skin Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15837	Excise Excess Skin Arm/Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.024 SUR716.001 SUR717.001 SUR701.024	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15838	Excise Excess Skin Fat Pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
		MD Criteria: Procedure/coning reviewed against Madis-I Asis- Colored Colored	SUR716.001	Cosmetic and Reconstructive Procedures		
15839	Excise Excess Skin & Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-
15847	Exc Skin Abd Add-On	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.017 SUR716.001	Surgical Treatment of Gynecomastia Cosmetic and Reconstructive Procedures		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	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 SUR701.024	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgery for Lipedema and Lymphedema	-	-

15877	Suction Lipectomy Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
15878	Suction Lipectomy Upr Extrem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001 SUR717.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	-
15879	Suction Lipectomy Lwr Extrem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024 SUR716.001 SUR717.001	Surgery for Lipedema and Lymphedema Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
15999	Removal Of Pressure Sore	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR701.024	Surgery for Lipedema and Lymphedema		_
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028		-	-
17106	Destruction Of Skin Lesions	predetermination to avoid post-service review.	SUR704.008 THE801.030	Laser Treatment of Congenitar Fort Wine Stain (FW3), Heritaligronias, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	THE801.028	Acne Management	-	-
17360	Skin Peel Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.028	Acne Management	-	_
17380	Hair Removal By Electrolysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
17999	Skin Tissue Procedure	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
19105	Cryosurg Ablate Fa Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	=	_
19300	Removal Of Breast Tissue	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.017	Surgical Treatment of Gynecomastia	-	_
19303	Mast Simple Complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR716.015 SUR717.001	Risk-Reducing (Prophylactic) Mastectomy  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
19316	Suspension Of Breast	Prior Authorization per contract agreement.	SUR716.010 SUR716.011	Mastopexy Reconstructive and Contralateral Mammaplasty	-	-
19318	Breast Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR716.001 SUR717.001	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
		Prior Authorization per contract agreement.	SUR716.011 SUR716.012	Reconstructive and Contralateral Mammaplasty Reduction Mammoplasty		
19324	Enlarge Breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive and Contralateral Mammaplasty	-	12/31/2020
19325	Breast Augmentation W/Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive and Contralateral Mammaplasty	_	_
19328	Rmvl Intact Breast Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009	Breast Implant, Removal and/or Insertion		
	· · · · · · · · · · · · · · · · · · ·	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011 SUR716.009	Reconstructive and Contralateral Mammaplasty  Breast Implant, Removal and/or Insertion		
19330	Rmvl Ruptured Breast Implant	predetermination to avoid post-service review.	SUR716.011 SUR716.009	Reconstructive and Contralateral Mammaplasty  Breast Implant, Removal and/or Insertion	_	_
19340	Insj Breast Implt Sm D Mast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR716.011	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive and Contralateral Mammaplasty	-	-
19342	Insj/Rplcmt Brst Implt Sep D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.009 SUR717.001 SUR716.011	Breast Implant, Removal and/or Insertion Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive and Contralateral Mammaplasty	-	-
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 and Contralateral Mammaplasty	_	_
19355	Correct Inverted Nipple(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
19357	Tiss Xpndr Plmt Brst Rcnstj	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive and Contralateral Mammaplasty	_	_
19361	Brst Rcnstj Latsms Drsi Flap	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Reconstructive and Contralateral Mammaplasty	_	_
19364	Brst Rcnstj Free Flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive and Contralateral Mammaplasty	_	_
19370	Revi Peri-Implt Capsule Brst	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.011	Reconstructive and Contralateral Mammaplasty		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.009	Breast Implant, Removal and/or Insertion	-	_
19371	Peri-Implt Capsic Brst Compl	predetermination to avoid post-service review.	SUR716.011	Reconstructive and Contralateral Mammaplasty  Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast	_	_
40.405	December 2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.021 SUR701.037	Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-		
19499	Breast Surgery Procedure	predetermination to avoid post-service review.	SUR701.031 SUR716.011	Conserving Surgery Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	-	-
20527	Inj Dupuytren Cord W/Enzyme	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Reconstructive and Contralateral Mammaplasty  Clostridial Collagenase for Fibroproliferative Disorders		
20560	Ndl Insj W/O Njx 1 Or 2 Musc	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	_	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
20561	Ndl Insj W/O Njx 3+ Musc	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.018	Dry Needling of Trigger Points for Myofascial Pain	-	-
20979	Us Bone Stimulation	predetermination to avoid post-service review.	DME101.030	Low Intensity Pulsed Ultrasound Fracture Healing Device	_	-
20982	Ablate Bone Tumor(S) Perq	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.021	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	-	-
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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	-	-
20999	Musculoskeletal Surgery	Unlisted: Procedure/service not specifically defined or classified, maybe 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)	_	_
21083	Prepare Face/Oral Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
21085	Prepare Face/Oral Prosthesis	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management	_	_
		Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
21089	Prepare Face/Oral Prosthesis	contract/clinical review.	- SUR716.001	Cosmetic and Reconstructive Procedures	-	-
21120	Paranetruction Of Chi-	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 SUR705.010	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Temporographily In Intel (TMI) Disorder (TMI)	-	-
			SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		

			SUR716.001	Cosmetic and Reconstructive Procedures		
21121	Reconstruction Of Chin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery		
		predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	_
			SUR705.010 SUR716.001	Temporomandibular Joint (TMJ) Disorders (TMJD)  Cosmetic and Reconstructive Procedures		
		AND Collected December (consider an income of contract And the Dellas Collected Collected Collected	SUR717.001	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 SUR706.009	Orthognathic Surgery	_	-
			SUR705.009 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		
21123	Neconstruction of Chin	predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
21125	Augmentation Lower Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR705.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Orthognathic Surgery	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
21127	Augmentation Lower Jaw Bone	Prior Authorization per contract agreement.	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
21141	Lefort I-1 Piece W/O Graft	Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010 SUR705.030	Temporomandibular Joint (TMJ) Disorders (TMJD)  Orthognathic Surgery		
21142	Lefort I-2 Piece W/O Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
			SUR705.010 SUR705.030	Temporomandibular Joint (TMJ) Disorders (TMJD) Orthognathic Surgery		
21143	Lefort I-3/> Piece W/O Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
		· · · · ·	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
21145	Lefort I-1 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030 SUR705.010	Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
21146	Lefort I-2 Piece W/ Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		_
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.010 SUR705.030	Temporomandibular Joint (TMJ) Disorders (TMJD) Orthognathic Surgery		_
21147	Lefort I-3/> Piece W/ Graft	Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	_
21150	Lefort li Anterior Intrusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery	_	
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Out and the Comment		
21151	Lefort Ii W/Bone Grafts	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	SUR705.030	Orthograthic Surgery		
		Prior Authorization per contract agreement.		Orthognathic Surgery	-	-
21159	Lefort Iii W/Fhdw/O Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	_
21160	Lefort Iii W/Fhd W/ Lefort I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require				
21188	Reconstruction Of Midface	Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
21193	Reconst Lwr Jaw W/O Graft	Prior Authorization per contract agreement.	SUR706.009 SUR705.010	Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
21194	Reconst Lwr Jaw W/Graft	Prior Authorization per contract agreement.	SUR706.009 SUR705.010	Sleep Related Breathing Disorders: Surgical Management Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Orthognathic Surgery		
21195	Reconst Lwr Jaw W/O Fixation	Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
			SUR705.010 SUR705.030	Temporomandibular Joint (TMJ) Disorders (TMJD) Orthognathic Surgery		
21196	Reconst Lwr Jaw W/Fixation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
		The radionation per contract agreement.	SUR705.010 SUR705.030	Temporomandibular Joint (TMJ) Disorders (TMJD) Orthognathic Surgery		
21198	Reconstr Lwr Jaw Segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
		Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
21199	Reconstr Lwr Jaw W/Advance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030 SUR706.009	Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management		
- 11	, , , , , , , , , , , , , , , , , , , ,	Prior Authorization per contract agreement.	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
21206	Reconstruct Upper Jaw Bone	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	_	_
24200	A Of Faulal Bassas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.030	Outh and this Course		
21208	Augmentation Of Facial Bones	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	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.028	Neuralgia Inducing Cavitational Osteonecrosis (NICO)		
21210	Face Bone Graft	Prior Authorization per contract agreement.	SUR705.030 SUR706.009	Orthognathic Surgery	-	-
			SUR705.028	Sleep Related Breathing Disorders: Surgical Management  Neuralgia Inducing Cavitational Osteonecrosis (NICO)		
21215	Lower Jaw Bone Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.030	Orthognathic Surgery	_	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management		
21244	Reconstruction Of Lower Jaw	predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	_
21246	Reconstruction Of Jaw	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
21248	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
21246	NECOUSTI OCCION OF JAW	review.	-	-	-	-
21249	Reconstruction Of Jaw	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
21299	Cranio/Maxillofacial Surgery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	_	_
21499	Head Surgery Procedure	contract/clinical review.	-	-	-	_
21685	Hyoid Myotomy & Suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
		predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to			_	
21899	Neck/Chest Surgery Procedure	contract/clinical review.	-	-	-	-
22505	Manipulation Of Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
22586	Prescri Fuse W/ Instr L5-S0	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR712.038	Axial Lumbosacral Interbody Fusion	-	-
		(CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
22899	Spine Surgery Procedure	contract/clinical review.	-	-	-	-
22999	Abdomen Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_	_
22470		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.032	Shoulder Perurfacing		
23470	Reconstruct Shoulder Joint	Prior Authorization per contract agreement.	3UK7U5.U32	Shoulder Resurfacing	-	-
23929	Shoulder Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	SUR705.032	Shoulder Resurfacing	-	_
24300	Manipulate Elbow W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.016	Manipulation Under Anesthesia		
		predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				_
24999	Upper Arm/Elbow Surgery	contract/clinical review.	-	-	-	_
25259	Manipulate Wrist W/Anesthes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.016	Manipulation Under Anesthesia	_	
		predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
25999	Forearm Or Wrist Surgery	contract/clinical review.	-	-	-	-

26340	Manipulate Finger W/Anesth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	-
26341	Manipulat Palm Cord Post Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for 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, maybe subject to contract/clinical review.	_	-	-	-
27275	Manipulation Of Hip Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	_	_
27279	Arthrodesis Sacroiliac Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.033	Sacroiliac Joint Fusion or Stabilization	_	_
27280	Fusion Of Sacroiliac Joint	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.033	Sacroiliac Joint Fusion or Stabilization	_	_
		Prior Authorization per contract agreement.	SUR702.017	Facet Joint and Sacroiliac Joint Denervation		
27299	Pelvis/Hip Joint Surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.019 SUR705.036	Hip Resurfacing (HR) Surgery for Groin Pain in Athletes	-	_
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)		
27412	Autochondrocyte Implant Knee	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions	-	-
27415	Osteochondral Knee Allograft	Prior Authorization per contract agreement.  Unlisted: Procedure/Service not specifically defined or classified, maybe subject to	SUR705.020	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	-	-
27599	Leg Surgery Procedure	contract/clinical review.	-	-	-	-
27702	Reconstruct Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.021	Total Ankle Replacement (TAR)	_	-
27703	Reconstruction Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.021	Total Ankle Replacement (TAR)	-	-
27860	Fixation Of Ankle Joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.016	Manipulation Under Anesthesia	-	-
27899	Leg/Ankle Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
28446	Osteochondral Talus Autogrft	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.020	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions		
		Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	
28890	Hi Enrgy Eswt Plantar Fascia	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
28899	Foot/Toes Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	-
29799	Casting/Strapping Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
29866	Autgrft Impint Knee W/Scope	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.020	Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	_	_
29867	Allgrft Impint Knee W/Scope	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.035 SUR705.020	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions  Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	_	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
29914	Hip Arthro W/Femoroplasty	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	-	-
29915	Hip Arthro Acetabuloplasty	Prior Authorization per contract agreement.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	-	-
29916	Hip Arthro W/Labral Repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR705.029	Surgical Treatment of Femoroacetabular Impingement (FAI)	-	-
29999	Arthroscopy Of Joint	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR705.029 SUR705.041	Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability		
29999	Artifioscopy Or Joint	contract/clinical review.	SUR705.024	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	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
30420	Reconstruction Of Nose	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR706.001 SUR717.001	Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		Prior Authorization per contract agreement.	SUR706.001	Nasal and Sinus Surgery		
30430	Revision Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
30430	Revision Of Nose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
30435	Revision Of Nose	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery	-	-
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 SUR706.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	- -
30435	Revision Of Nose	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001 SUR706.001 SUR717.001 SUR706.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasal and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	- - - 5/15/2021	- - -
30435	Revision Of Nose  Revision Of Nose	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR717.001 SUR706.001 SUR717.001 SUR706.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery	- - - 5/15/2021	- - -
30435 30450 30468	Revision Of Nose  Revision Of Nose  Rpr Nsl Viv Collapse W/Implt	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPC028, which is one of our Clinical Payment and Coding Policy (CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.	SUR717.001 SUR706.001 SUR717.001 SUR706.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Absorbable Nasai Implant for Treatment of Nasai Valve Collapse	- - - 5/15/2021 -	- - - -
30435 30450 30468 30999	Revision Of Nose  Revision Of Nose  Rpr NsI Viv Collapse W/Implt  Nasal Surgery Procedure	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR717.001 SUR706.001 SUR717.001 SUR706.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Absorbable Nasai Implant for Treatment of Nasai Valve Collapse	- - - 5/15/2021 - -	- - - -
30435 30450 30468 30999 31299	Revision Of Nose  Revision Of Nose  Rpr Nsl Viv Collapse W/Implt  Nasal Surgery Procedure  Sinus Surgery Procedure	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR717.001 SUR706.001 SUR717.001 SUR706.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasai and Sinus Surgery Absorbable Nasai Implant for Treatment of Nasai Valve Collapse	- - 5/15/2021 - -	- - - - -
30435 30450 30468 30999 31299 31599	Revision Of Nose  Revision Of Nose  Rpr Nsl Viv Collapse W/Implt  Nasal Surgery Procedure  Sinus Surgery Procedure  Larynx Surgery Procedure	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CCPC028, which is one of our Clinical Payment and Coding Policy (CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Sprocedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed.	SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR706.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nasail and Sinus Surgery Absorbable Nasail Implant for Treatment of Nasail Valve Collapse	- - - 5/15/2021 - -	- - - - - -
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See	33368	Replace Aortic Valve W/Byp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.028	Transcatheter Aortic-Valve Implantation for Aortic Stenosis	_	_
with the second process of the second proces	33542	Removal Of Heart Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.026	Cardiac Restoration and Remodeling Procedures	_	_
Professional Content	33548	Restore/Remodel Ventricle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.026	Cardiac Restoration and Remodeling Procedures		
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Section   Personal Process   P	33999	Cardiac Surgery Procedure		SUR701.009	Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation	-	-
Manual   M	36299	Vessel Injection Procedure		_	-	-	_
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377.18         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         — — — — — — — — — — — — — — — — — — —	37215 37216 37217 37218 37241 37242 37243 37244 37500	Transcath Stent Cca W/Eps Transcath Stent Cca W/O Eps Stent Placemt Retro Carotid Stent Placemt Ante Carotid Vasc Embolize/Occlude Venous Vasc Embolize/Occlude Artery Vasc Embolize/Occlude Organ Vasc Embolize/Occlude Bieed Endoscopy Ligate Perf Veins	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to	SUR701.028  SUR701.028  SUR701.028  SUR701.028  SUR701.015  SUR701.015  RAD601.047  SUR701.015  THE801.022  SUR701.015	Extracranial Carotid Angioplasty or Stenting  Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions  Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions  Badioembolization for Primary and Metastatic Tumors of the Liver  Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions  Transcatheter Arterial Chemoembolization (TACE) of the Liver  Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions	-	- - - - - - - -
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11	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 SUR703.036 SUR703.039 SUR703.039 SUR703.041 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.050 SUR703.050	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 Reats 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 Lymphonoytic Leukemia Hematopoietic Cell Transplantation for Foltenial Ovarian Cancer Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Malignant Astrocytomia and Giomas Hematopoietic Cell Transplantation for Malignant Astrocytomia and Giomas Hematopoietic Cell Transplantation for Malignant Astrocytomia and Giomas Hematopoietic Cell Transplantation for Moleginal Tymphoma (HL) Hematopoietic Cell Transplantation for Moleginal Tymphomas Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pismar Sell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Pismar Systemic Amyloidosis Hematopoietic Cell Transplantation for Malignant Astrocytomia Malignantion Hematopoietic Cell Transplantation for Malignant Astrocytomia Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Solid Tumors in Children	-
W	98206	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 SUR703.045 SUR703.056 SUR703.058 SUR703.059 SUR703.041 SUR703.041 SUR703.045 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.040 SUR703.055 SUR703.055 SUR703.055 SUR703.065 SUR703.065 SUR703.065 SUR703.065 SUR703.065	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (HCT) or Additional infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Autoimmuno Biseases Hematopoietic Cell Transplantation for Autoimmuno Biseases Hematopoietic Cell Transplantation for Chronic 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 Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Meloid Stephenous 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 Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome 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 Misloren Maccoglobulinenia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-
=	38207	Cryopreserve Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.029 SUR703.029 SUR703.029 SUR703.039 SUR703.039 SUR703.039 SUR703.034 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035	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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Additional Infusion Following Preparative Regimens (General Donor and Recipient Information Hematopoietic Cell Transplantation for Automume Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Epithelal Ovarian Cancer Lematopoietic Cell Transplantation for Epithelal Ovarian Cancer Lematopoietic Cell Transplantation for Hodgike Intymphoma (HL) Hematopoietic Cell Transplantation for Hodgike Intymphoma (HL) Hematopoietic Cell Transplantation for Moleodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for For Micromory in Children Hematopoietic Cell Transplantation for Maldenstrom Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-

38208	Thaw Preserved Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.038 SUR703.029 SUR703.042 SUR703.004 SUR703.037 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035	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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Entonic Myeloid Leukemia Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Neveroietic Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Arnyloidosis Hematopoietic Cell Transplantation for Primary Systemic Arnyloidosis Hematopoietic Cell Transplantation for Walderstorm Macroglobulinemia Hematopoietic Cell Transplantation for Walderstorm Macroglobulinemia Hematopoietic Cell Transplantation for Walderstorm Macroglobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Turnors	
38209	Wash Harvest Stem Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.038 SUR703.029 SUR703.002 SUR703.035 SUR703.035 SUR703.039 SUR703.034 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.045	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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Off Tumors in Children Hematopoietic Cell Transplantation for Midenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Moldenstrom Macroglobulinemia	
38210	T-Cell Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.038 SUR703.029 SUR703.002 SUR703.004 SUR703.003 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.044	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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Mailignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer 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 Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Myelogramic Myelogramical Hematopoietic Cell Transplantation for Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Pinary 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.	SUR703.043 SUR703.047 SUR703.038 SUR703.038 SUR703.002 SUR703.042 SUR703.037 SUR703.036 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.044 SUR703.045	Hematopoletic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoletic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoletic Cell Transplantation for Breast Cancer Hematopoletic Cell Transplantation for Breast Cancer Hematopoletic Cell Transplantation for Chronic Lymphorytic Leukemia (CLL) and Small Lymphocytic Lymphoma (St. Lill Transplantation for Mallgnant Astrocytomas and Gilomas Hematopoletic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoletic Cell Transplantation for Autoimmune Diseases Hematopoletic Cell Transplantation for Autoimmune Diseases Hematopoletic Cell Transplantation for Patrol Myelodic Leukemia (AML) Hematopoletic Cell Transplantation for Patrol Patro	

38212	Rbc Depletion Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.029 SUR703.029 SUR703.002 SUR703.037 SUR703.035 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.044	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Chronic Myelodid Leukemia Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Polismo Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Polismo Cell Dyscrasias, Including Multiple Myeloma (MM) and Hematopoietic Cell Transplantation for Myelodysiastic Macoglobuliemia Hematopoietic Cell Transplantation for Molismo Macoglobuliemia Hematopoietic Cell Transplantation for Myelodysiastic Macoglobuliemia Hematopoietic Cell Transplantation for Myelodysiastic Macoglobuliemia	-
38213	Platelet Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.038 SUR703.039 SUR703.042 SUR703.035 SUR703.035 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.044 SUR703.045	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Rreast Cancer Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Foreix Cancer Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gilomas Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Foreix Diveloid Leukemia Hematopoietic Cell Transplantation for Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Myelogenous Leukemia Hematopoietic Cell Transplantation for Hordickin Lymphoma (HL) Hematopoietic Cell Transplantation for Hordickin Lymphoma (HL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Foreix Dispersion (Ell Pyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Trumors in Children Hematopoietic Cell Transplantation for Foreix Syndrome (Mallogobulinemia Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	-
38214	Volume Deplete Of Harvest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.039 SUR703.042 SUR703.042 SUR703.035 SUR703.035 SUR703.039 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.045	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) 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 (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Chronic Myelodid Leukemia 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 Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Ordinary Systemic Amyloidosis Hematopoietic Cell Transplantation for Myelodysma Macroglobulinemia	-
38215	Harvest Stem Cell Concentrte	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.043 SUR703.047 SUR703.038 SUR703.039 SUR703.042 SUR703.035 SUR703.035 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.031 SUR703.035 SUR703.041 SUR703.035 SUR703.045 SUR703.045 SUR703.045 SUR703.045	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Malignant Astrocytoms and Gilomas Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Chronic Myelodi Leukemia Hematopoietic Cell Transplantation for Chronic Myelodid Leukemia Hematopoietic Cell Transplantation for Chronic Myelodid Leukemia Hematopoietic Cell Transplantation for Melodgkin Lymphoma (HL) Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MEPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis	-

				Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)  Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)	
			SUR703.043	Hematopoietic Cell Transplantation for Acquired immunodeficiency Syndrome (AIDS)  Hematopoietic Cell Transplantation for Breast Cancer	
			SUR703.047	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic	
			SUR703.038 SUR703.029	Lymphoma (SLL)  Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas	
			SUR703.042	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas  Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General	
			SUR703.002	Donor and Recipient Information)	
			SUR703.037 SUR703.036	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases	
			SUR703.039	Hematopoietic Cell Transplantation for Autoimmune Diseases  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR703.041	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia	
38230	Bone Marrow Harvest Allogen	Prior Authorization per contract agreement.	SUR703.034 SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	
			SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias  Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)	
			SUR703.035	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults	
			SUR703.032 SUR703.031	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN)	
			SUR703.030	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas	
			SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and	
			SUR703.044	POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	
			SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis  Hematopoietic Cell Transplantation for Solid Tumors in Children	
				Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia	
				Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	
				Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)	
				Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)  Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)	
			SUR703.043	Hematopoietic Cell Transplantation for Breast Cancer	
			SUR703.047	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic	
			SUR703.038 SUR703.029	Lymphoma (SLL)  Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas	
			SUR703.042	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General	
			SUR703.002	Donor and Recipient Information)	
			SUR703.037 SUR703.036	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases	
			SUR703.036 SUR703.039	Hematopoietic Cell Transplantation for Autoimmune Diseases  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.041	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia	
38232	Bone Marrow Harvest Autolog	predetermination to avoid post-service review.	SUR703.034	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	
			SUR703.033 SUR703.040	Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias  Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)	
			SUR703.035	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults	
			SUR703.032	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative	
			SUR703.031	Neoplasms (MPN)  Hematopoletic Cell Transplantation for Non-Hodgkin Lymphomas	
			SUR703.030 SUR703.046	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and	
			SUR703.044	POEMS Syndrome	
			SUR703.050	Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis	
			SUR703.045	Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia	
				Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	
				Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)  Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)	
			SUR703.043	Hematopoietic Cell Transplantation for Acquired Infinition deficiency syndrome (AIDS)  Hematopoietic Cell Transplantation for Breast Cancer	
			SUR703.047	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic	
			SUR703.038	Lymphoma (SLL)	
			SUR703.029	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas  Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General	
			SUR703.042 SUR703.002	Donor and Recipient Information)	
			SUR703.002 SUR703.037	Donor and Recipient Information) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AML)	
			SUR703.002 SUR703.037 SUR703.036	Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases	
			SUR703.002 SUR703.037 SUR703.036 SUR703.039	Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma	
38240	Transpit Allo Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for needed remination to avoid nost service review.	SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034	Donor and Recipient Information)  Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma  Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia  Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	
38240	Transpit Alio Hct/Donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.033	Donor and Recipient Information) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoletic Cell Transplantation for Autoimmune Diseases Hematopoletic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoletic Cell Transplantation for Chronic Myeloid Leukemia Hematopoletic Cell Transplantation for Epithelial Ovarian Cancer Hematopoletic Cell Transplantation for Genetic Diseases and Acquired Anemias	
38240	Transpit Alio Hct/Donor		SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.033 SUR703.040	Donor and Recipient Information)  Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases  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 Benetic Diseases and Acquired Anemias  Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)	
38240	Transpit Allo Hct/Donor		SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.033	Donor and Recipient Information) Hematopoletic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoletic Cell Transplantation for Autoimmune Diseases Hematopoletic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoletic Cell Transplantation for Chronic Myeloid Leukemia Hematopoletic Cell Transplantation for Epithelial Ovarian Cancer Hematopoletic Cell Transplantation for Genetic Diseases and Acquired Anemias	
38240	Transpit Allo Hct/Donor		SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.035 SUR703.035	Donor and Recipient Information)  Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma  Hematopoietic Cell Transplantation for Chroin (Wyeloid Leukemia  Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer  Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias  Hematopoietic Cell Transplantation for Hodgist Lymphoma (Hu)  Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative  Neoplasms (MPN)	
38240	Transpit Allo Hct/Donor		SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.030 SUR703.035 SUR703.035 SUR703.031 SUR703.031	Donor and Recipient Information) Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Central Neyleiodi Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer 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 Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas	
38240	Transpit Allo Hct/Donor		SUR703.002 SUR703.037 SUR703.036 SUR703.039 SUR703.041 SUR703.034 SUR703.033 SUR703.040 SUR703.035 SUR703.035	Donor and Recipient Information)  Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation for Autoimmune Diseases  Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma  Hematopoietic Cell Transplantation for Chroin (Wyeloid Leukemia  Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer  Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias  Hematopoietic Cell Transplantation for Hodgist Lymphoma (Hu)  Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative  Neoplasms (MPN)	-
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38242	Transpit Alio Lymphocytes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.043 SUR703.045 SUR703.036 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.034 SUR703.034 SUR703.042 SUR703.035 SUR703.045 SUR703.035 SUR703.035 SUR703.035 SUR703.035 SUR703.045	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (FU) or Additional Infusion Following Preparative Regimens (Genera 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 Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (Ell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (Ell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (Ell Transplantation for Chronic Myeloid Leukemia Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Melignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, including Multiple Myeloma (MM) and Hematopoietic Cell Transplantation for Formary Systemic Amyloidosis Hematopoietic Cell Transplantation for Frimary Systemic Amyloidosis Hematopoietic Cell Transplantation for Myeloghatic Macroglobulinemia Hematopoietic Cell Transplantation for Mallednstrom Macroglobulinemia Hematopoietic Cell Transplantation for Haldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Haldenstrom Macroglobulinemia	-	-
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 SUR703.003 SUR703.043 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.029 SUR703.041 SUR703.044 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.046 SUR703.055 SUR703.046 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.064 SUR703.064 SUR703.064 SUR703.064	Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (Genera Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for General Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation for Fithelial Ovarian Cancer Hematopoietic Cell Transplantation for Fithelial Ovarian Cancer Hematopoietic Cell Transplantation for Fothyloside Systems (AIDS) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative Neoplasms (MPN) Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and POEMS Syndrome Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Molicial Tumors in Children Hematopoietic Cell Transplantation for Molicial Tumors in Children Hematopoietic Cell Transplantation for Non-Molicial Tumors in Children Hematopoietic Cell Transplantation for Molicial Tumors in Children	-	-
38308	Incision Of Lymph Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.024	Surgery for Lipedema and Lymphedema	_	_
38589	Laparoscope Proc Lymphatic	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_			_
38999	Blood/Lymph System Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-		_
		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	_
39499	Chest Procedure	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
39599	Diaphragm Surgery Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	_
40799	Lip Surgery Procedure	contract/clinical review.	-	-	-	-
40899	Mouth Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
41530	Tongue Base Vol Reduction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR701.021 SUR706.009	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver Sleep Related Breathing Disorders: Surgical Management	_	_
	Tongue And Mouth Surgery	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to	301700.009	Sieep related dreaming disorders. Surgical Management		
41599		contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
41820	Excision Gum Each Quadrant	review.	-	-	-	_
41821	Excision Of Gum Flap	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
41822	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
41823	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
41828	Excision Of Gum Lesion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
41830	Removal Of Gum Tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
41870	Gum Graft	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
41872	Repair Gum	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
41874		review.		<del>-</del>		
	Repair Tooth Socket	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
	Repair Tooth Socket	review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-		_
41899	Dental Surgery Procedure	review.			-	-
41899 42145	Dental Surgery Procedure  Repair Palate Pharynx/Uvula	review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	- SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
41899 42145 42299	Dental Surgery Procedure	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	- - SUR706.009	Sleep Related Breathing Disorders: Surgical Management -	- - -	-
41899 42145	Dental Surgery Procedure  Repair Palate Pharynx/Uvula	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - SUR706.009 -		- - -	-
41899 42145 42299	Dental Surgery Procedure  Repair Palate Pharynx/Uvula  Palate/Uvula Surgery	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - SUR706.009 - -	- Sleep Related Breathing Disorders: Surgical Management		- - - -
41899 42145 42299 42699	Dental Surgery Procedure  Repair Palate Pharynx/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure	review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPRO28, which is one of our Clinical Payment and Coding Policy	- SUR706.009 - - - MED201.038		-	-
41899 42145 42299 42699 42999 43206	Dental Surgery Procedure  Repair Palate Pharymy/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy	review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- - - MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
41899 42145 42299 42699 42999	Dental Surgery Procedure  Repair Palate Pharynv/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure	review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Click EIU policy CPCPO28, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	-	-	-	-
41899 42145 42299 42699 42999 43206	Dental Surgery Procedure  Repair Palate Pharymy/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy	review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- - - MED201.038	Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)	- - - - - -	-
41899 42145 42299 42699 42999 43206 43210	Dental Surgery Procedure  Repair Palate Pharynv/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy  Egd Esophagogastrc Endopisty	review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  CPCPD.  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.  EIU: 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.	- MED201.038  MED201.016  SUR716.003  RX501.019	Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Bariatric Surgery  Botulinum Toxin		-
41899 42145 42299 42699 43206 43210 43236	Dental Surgery Procedure  Repair Palate Pharynx/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy  Egd Esophagogastrc Endopisty  Uppr Gi Scope W/Submuc Inj  Egd Optical Endomicroscopy	review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCPQ3, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EU policy CPCPQ3, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for MP Criteria: Procedure/service review.	— — — — — — — — — — — — — — — — — — —	Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Bariatric Surgery  Botulinum Toxin  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Confocal Laser Endomicroscopy (CLE)		-
41899 42145 42299 42699 43206 43210 43236 43252 43253	Dental Surgery Procedure  Repair Palate Pharynx/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy  Egd Esophagogastrc Endoplsty  Uppr Gi Scope W/Submuc Inj  Egd Optical Endomicroscopy  Egd Us Transmural Injxn/Mark	review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not enimbursed by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service rot reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	— — — — — — — — — — — — — — — — — — —	Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Bariatric Surgery  Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD)  Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)		-
41899 42145 42299 42699 43206 43210 43236	Dental Surgery Procedure  Repair Palate Pharynx/Uvula  Palate/Uvula Surgery  Salivary Surgery Procedure  Throat Surgery Procedure  Esoph Optical Endomicroscopy  Egd Esophagogastrc Endopisty  Uppr Gi Scope W/Submuc Inj  Egd Optical Endomicroscopy	review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPC028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review against Medical Policy Criteria. Submit for predetermination to avoid post-service review against Medical Policy Criteria. Submit for predetermination to avoid post-service review against Medical Policy Criteria. Submit for predetermination to avoid post-service review against Medical Policy Criteria.	— — — — — — — — — — — — — — — — — — —	Confocal Laser Endomicroscopy (CLE)  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Bariatric Surgery  Botulinum Toxin  Device Therapies for Gastroesophageal Reflux Disease (GERD)  Confocal Laser Endomicroscopy (CLE)		

43284	Laps Esophgl Sphnctr Agmntj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.036	Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD)	-	-
43289	Laparoscope Proc Esoph	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	MED201.016	Device Therapies for Gastroesophageal Reflux Disease (GERD)	-	-
43499	Esophagus Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.	-	-	-	-
43633	Removal Of Stomach Partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43644	Lap Gastric Bypass/Roux-En-Y	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43645	Lap Gastr Bypass Incl Smll I	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	_
43647	Lap Impl Electrode Antrum	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR709.031	Gastric Electrical Stimulation (GES)		
43648	Lap Revise/Remy Eltrd Antrum	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR709.031	Gastric Electrical Stimulation (GES)	-	-
43659		Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	301703.031	destrict lectrical stillingston (OCs)	-	-
	Laparoscope Proc Stom	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-		-	-
43770	Lap Place Gastr Adj Device	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	
43771	Lap Revise Gastr Adj Device	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	-	_
43772	Lap Rmvl Gastr Adj Device	predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43773	Lap Replace Gastr Adj Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	_
43774	Lap Rmvl Gastr Adj All Parts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	_
43775	Lap Sleeve Gastrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43842	V-Band Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43843	Gastroplasty W/O V-Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43845	Gastroplasty Duodenal Switch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	_
43846	Gastric Bypass For Obesity	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	_	_
43847	Gastric Bypass Incl Small I	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
43848	Revision Gastroplasty	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	-	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	_
43881	Impl/Redo Electrd Antrum	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.031	Gastric Electrical Stimulation (GES)	-	-
43886	Revise Gastric Port Open	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery	-	
43887	Remove Gastric Port Open	predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	_	_
43888	Change Gastric Port Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.003	Bariatric Surgery	-	_
43999	Stomach Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
44238	Laparoscope Proc Intestine	Unlisted: Procedure/service not specifically defined or classified, maybe 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 Intestine	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	_
44899	Bowel Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_	_
44979	Laparoscope Proc App	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_		_	_
45399	Unlisted Procedure Colon	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
45499	Laparoscope Proc Rectum	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		-
45999		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	<u>-</u>	-	-
45555	Rectum Surgery Procedure	contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	-
46707	Repair Anorectal Fist W/Plug	Check EIU policy CPCP028, 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, maybe subject to contract/clinical review.	_	-	_	-
47370	Laparo Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	-	_
47371	Laparo Ablate Liver Cryosurg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.032	Cryosurgical Ablation of Primary or Metastatic Liver Tumors	-	-
47379	Laparoscope Procedure Liver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
47380	Open Ablate Liver Tumor Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR709.029	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors	_	_
47382	Percut Ablate Liver Rf	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.038	Microwave Tumor Ablation Padiofraguescy Ablation (PEA) of Primary or Metastatic Liver Tumors	_	_
47383	Perq Ablti Lvr Cryoablation	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.029 SUR701.032	Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors  Cryosurgical Ablation of Primary or Metastatic Liver Tumors		
47399	Liver Surgery Procedure	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	**		<u>-</u>	_
47579	Laparoscope Proc Biliary	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-		_	_
47999	Bile Tract Surgery Procedure	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.	AIM Guidelines	-	-	-
48999	Pancreas Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_			_
49329	Laparo Proc Abdm/Per/Oment	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_		_
49659	Laparo Proc Hernia Repair	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
	.,	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
49999 50250	Abdomen Surgery Procedure  Cryoablate Renal Mass Open	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	-	-
30230	- yourace mental midss Open	predetermination to avoid post-service review.  MD Citaria Presenture (continued against Madical Balias Citaria Submit for	SUR703.007	Cryosurgical Ablation or Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors  Kidney Transplant	-	-
50360	Transplantation Of Kidney	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.008 SUR703.013	Liver Transplant and Combined Liver-Kidney Transplant Pancreas and Related Organ Tissue Transplantation	-	_
50541	Laparo Ablate Renal Cyst	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018 SUR701.021	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	_	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors		
50542	Laparo Ablate Renal Mass	predetermination to avoid post-service review.	SUR701.021	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	-	-
50549	Laparoscope Proc Renal	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
50592	Perc Rf Ablate Renal Tumor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.038 SUR701.021	Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver	_	-

50593	Perc Cryo Ablate Renal Tum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.018	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumor	'S _	-
50949	Laparoscope Proc Ureter	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
51715	Endoscopic Injection/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	_	_
51999	Laparoscope Proc Bla	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to			_	
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	<u>-</u>	-	-
52327	Cystoscopy Inject Material	predetermination to avoid post-service review.	SUR710.022	Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	-	_
52441	Cystourethro W/Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH)	-	_
52442	Cystourethro W/Addl Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH)	-	_
53860	Transurethral Rf Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	SUR710.021	Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI)		
33000	Transuretinarki Treatment	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	30K/10.021	readion equency energy therapy for stress or mary incontinence (50)	-	-
53899	Urology Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
54125	Removal Of Penis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	_	_
54200	Treatment Of Penis Lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders		
	Tourstand Of Deals Lealer	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	Treatment Of Penis Lesion	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	-	
54400	Insert Semi-Rigid Prosthesis	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	_
54401	Insert Self-Contd Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	-	-
54405	Insert Multi-Comp Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	_	_
54406	Remove Muti-Comp Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
54408	Repair Multi-Comp Penis Pros	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	-	
54410	Remove/Replace Penis Prosth	predetermination to avoid post-service review.	MED201.030	Sexual Dysfunctions, Assessment and Treatment	-	_
54411	Remov/Replc Penis Pros Comp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	_	_
54415	Remove Self-Contd Penis Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment	_	_
54416	Remv/Repl Penis Contain Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030 SUR717.001	Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
54417	Remv/Replc Penis Pros Compl	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.030 SUR716.001	Sexual Dysfunctions, Assessment and Treatment Cosmetic and Reconstructive Procedures	-	
54660	Revision Of Testis	predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	_
54699	Laparoscope Proc Testis	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
55559	Laparo Proc Spermatic Cord	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
55706	Prostate Saturation Sampling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR717.015	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		3D Mapping with Biopsy	2/4/2024	
55880	Abltj Mal Prst8 Tiss Hifu	predetermination to avoid post-service review.	SUR717.014 SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer  High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer	2/1/2021	-
55899	Genital Surgery Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR701.031	Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)	_	_
55970	Sex Transformation M To F	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.019 SUR717.001	Nerve Graft With Radical Prostatectomy  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
33370	Sex Transformation William					
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
55980	Sex Transformation F To M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
55980 56805	Sex Transformation F To M  Repair Clitoris	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	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
		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		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
56805	Repair Clitoris	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	- - -
56805 56810 57291	Repair Clitoris  Repair Of Perineum  Construction Of Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR717.001 MED201.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
56805 56810 57291 57292	Repair Clitoris  Repair Of Perineum  Construction Of Vagina  Construct Vagina With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service 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.	SUR717.001 SUR717.001 MED201.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
56805 56810 57291	Repair Clitoris  Repair Of Perineum  Construction Of Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR717.001 MED201.030 SUR717.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	-
56805 56810 57291 57292	Repair Clitoris  Repair Of Perineum  Construction Of Vagina  Construct Vagina With Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.001 SUR717.001 MED201.030 SUR717.001 SUR717.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Plugs for Fistula Repair	-	- - - - - -
56805 56810 57291 57292 57296	Repair Of Perineum  Construction Of Vagina  Construct Vagina With Graft  Revise Vag Graft Open Abd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed.	SUR717.001 SUR717.001 MED201.030 SUR717.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	- - - - - - -
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56805 56810 57291 57292 57296 57307 57335	Repair Clitoris  Repair Of Perineum  Construction Of Vagina  Construct Vagina With Graft  Revise Vag Graft Open Abd  Fistula Repair & Colostomy  Repair Vagina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service nespectically defined or classified, maybe subject to	SUR717.001 SUR717.001 MED201.030 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Plugs for Fistula Repair  Gender Assignment Surgery and Gender Reassignment Surgery with Related Services  Sexual Dysfunctions, Assessment and Treatment	-	- - - - - - - -
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56805 56810 57291 57292 57296 57307 57335 57426 58578	Repair Cilitoris  Repair Of Perineum  Construction Of Vagina  Construct Vagina With Graft  Revise Vag Graft Open Abd  Fistula Repair & Colostomy  Repair Vagina  Revise Prosth Vag Graft Lap  Laparo Proc Uterus  Hysteroscope Procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unitsted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.	SUR717.001 SUR717.001 MED201.030 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Plugs for Fistula Repair Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		-
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62287	Percutaneous Diskectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR712.004 SUR712.037	Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy  Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency	_	_
64561	Implant Neuroelectrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR710.018	Coblation (Nucleoplasty)  Sacral Nerve Neuromodulation/Stimulation		
64566	Neuroeltrd Stim Post Tibial	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.035		-	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Percutaneous Tibial Nerve Stimulation (PTNS)	-	-
64581	Implant Neuroelectrodes	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	-	-
64640	Injection Treatment Of Nerve	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.040	Ablation of Peripheral Nerves to Treat Pain	5/15/2021	12/31/2999
64809	Remove Sympathetic Nerves	predetermination to avoid post-service review.	MED201.014	Treatment of Hyperhidrosis	_	_
64999	Nervous System Surgery	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.	_	-	-	_
65760	Revision Of Cornea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.001	Refractive and Therapeutic Keratoplasty		
65770	Revise Cornea With Implant	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030		-	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Keratoprosthesis	-	-
65785	Impltj Ntrstrml Crnl Rng Seg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.031	Implantation of Intrastromal Corneal Ring Segments	-	_
66174	Translum Dil Eye Canal	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.032	Viscocanalostomy and Canaloplasty	-	_
66175	Trnslum Dil Eye Canal W/Stnt	predetermination to avoid post-service review.	SUR713.032	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.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	-	-
66180	Aqueous Shunt Eye W/Graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	5/1/2021	12/31/2999
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, maybe subject to	_	_	_	_
67299	Eye Surgery Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_		_
67399	Unlisted Px Extraocular Musc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to			-	
67599	Orbit Surgery Procedure	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to			-	
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	- SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67900	Repair Brow Defect	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR712.031	Surgical Deactivation of Headache Trigger Sites	-	-
67901	Repair Eyelid Defect	predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67902	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67903	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	-
67904	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	-	_
67906	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67908	Repair Eyelid Defect	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.004	Blepharoplasty, Blepharoptosis and Brow Repair	_	_
67999	Revision Of Eyelid	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
68399	Eyelid Lining Surgery	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
68899	Tear Duct System Surgery	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	_ <del>-</del>	-	
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	- Country and December 1 to December 2	-	_
69090	Pierce Earlobes	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR716.001	Cosmetic and Reconstructive Procedures	_	_
69399	Outer Ear Surgery Procedure	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	-
69705	Nps Surg Dilat Eust Tube Uni	predetermination to avoid post-service review.	SUR706.018	Balloon Dilation of the Eustachian Tube	1/15/2021	-
69706	Nps Surg Dilat Eust Tube Bi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR706.018	Balloon Dilation of the Eustachian Tube	1/15/2021	-
69714	Implant Temple Bone W/Stimul	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require 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 Revision	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_
69718	Revise Temple Bone Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	_	_
69799	Middle Ear Surgery Procedure	Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
69930	Implant Cochlear Device	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant		
		Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	301714.004	Council implant	-	-
69949	Inner Ear Surgery Procedure	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	_
69979	Temporal Bone Surgery	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-		-	-
76496	Fluoroscopic Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
76497	Ct Procedure	contract/clinical review.	-	-	-	-
76498	Mri Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
76499	Radiographic Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
76999	Echo Examination Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
77299	Radiation Therapy Planning	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
77399	External Radiation Dosimetry	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_		_	_
77499	Radiation Therapy Management	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
77799	Radium/Radioisotope Therapy	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
78099	Endocrine Nuclear Procedure	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-		-	-
78199	Blood/Lymph Nuclear Exam	contract/clinical review.	-	-	-	-
78299	Gi Nuclear Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
78399	Musculoskeletal Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
78499	Cardiovascular Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
78599	Respiratory Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
78699	Nervous System Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
		and any and the second				

78799	Genitourinary Nuclear Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
78999	Nuclear Diagnostic Exam	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
79999	Nuclear Medicine Therapy	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
80299	Quantitative Assay Drug	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
81099	Urinalysis Test Procedure	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		_
		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>	-	-
81479	Unlisted Molecular Pathology	contract/clinical review. May require Prior Authorization per contract agreement.	-	-	-	-
81599	Unlisted Maaa	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	AIM Guidelines	-	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with		
82523	Collagen Crosslinks	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	High Bone Turnover	-	-
83695	Assay Of Lipoprotein(A)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	_	
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		<u> </u>		
83698	Assay Lipoprotein Pla1	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.134	Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk	-	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
83701	Lipoprotein Bld Hr Fraction	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
83704	Lipoprotein Bld Quan Part	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease		
	, , , , , , , , , , , , , , , , , , ,	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		· · · · · · · · · · · · · · · · · · ·		-
83722	Lipoprtn Dir Meas Sd Ldl Chl	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with		
83937	Assay Of Osteocalcin	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.116	High Bone Turnover	-	-
83987	Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED201.024	Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders		
03307	Exhaled Breath Condensate	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	WEDEDI.OE4	measurement of Exhaust Steam condensate in the Shighost and Management of Respiratory States		
84112	Eval Amniotic Fluid Protein	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy	-	-
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
84431	Thromboxane Urine	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.148	Measurement of Thromboxane Metabolites in Urine	-	-
84999	Clinical Chemistry Test	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review	AIM Guidelines	-	_	_
85999	Hematology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
		contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
86001	Allergen Specific Igg	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED206.001	Allergy Management	-	-
86343	Leukocyte Histamine Release	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED206.001	Allergy Management		
	·	(CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
86486	Skin Test Nos Antigen	contract/clinical review.	-	-	-	-
86849	Immunology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
86910	Blood Typing Paternity Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
86911	Blood Typing Antigen System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	-
86999	Transfusion Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
87505	Nfct Agent Detection Gi	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	Gastrointestinal Panels	_	_
87506	ladna-Dna/Rna Probe Tq 6-10	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	Gastrointestinal Panels		
87507	ladna-Dna/Rna Probe Tq 12-24	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED207.155	Gastrointestinal Panels		
		predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	WED207.153	Gastronitesunal Fanets	_	-
87797	Detect Agent Nos Dna Dir	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
87798	Detect Agent Nos Dna Amp	contract/clinical review.	-	-	-	-
87799	Detect Agent Nos Dna Quant	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	-
87899	Agent Nos Assay W/Optic	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	-
87999	Microbiology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	-
88000	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
88005	Autopsy (Necropsy) Gross	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	
88007	Autopsy (Necropsy) Gross	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
88012	Autopsy (Necropsy) Gross	review.	-	-	-	-
88014						-
00014	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	<u></u>	-	
88016	Autopsy (Necropsy) Gross Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	- -	<u>-</u> -	-
88016	Autopsy (Necropsy) Gross	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	- - -	- - -	- - -	-
88016 88020	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	- - - -	- - -	-
88016 88020 88025	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	- - - -	-	-
88016 88020 88025 88027 88028	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Autopsy (Necropsy) Complete Autopsy (Necropsy) Complete Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	- - - - -	-	-
88016 88020 88025 88027 88028 88029	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-	-
88016 88020 88025 88027 88028 88029 88036	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		- - - - -	- - - -
88016 88020 88025 88027 88028 88028 88029 88036	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy Limited Autopsy Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - - - -		- - - - -	- - - - - -
88016 88020 88025 88027 88028 88029 88036	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-			-
88016 88020 88025 88027 88028 88028 88029 88036	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy Limited Autopsy Limited Autopsy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - - - - -			-
88016 88020 88025 88027 88028 88029 88036 88037	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy Limited Autopsy Forensic Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - - - - - - - -			
88016 88020 88025 88027 88028 88029 88036 88037 88040	Autopsy (Necropsy) Gross Autopsy (Necropsy) Complete Limited Autopsy Limited Autopsy Eronsic Autopsy (Necropsy) Coroners Autopsy (Necropsy)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- - - - - - - - -			

Mode							
Marie	88299	Cytogenetic Study		-	-	-	-
	00275	Ontired Sententine contracts	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	MED204 020	Confeed land Federal Income (CCF)		
1985   1985	883/5	Optical Endomicroscpy Interp	(CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
Section   Process	88399	Surgical Pathology Procedure		-	-	-	_
1968   1968	88749	In Vivo Lab Service		_	-	-	_
300         Secondary Section of Section Secti	89240	Pathology Lab Procedure		_	_	_	_
Second	89258	Cryopreservation Embryo(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
Second				_	<u></u>		-
Non-Normal No.   Non-Normal No.   Non-Normal No.   Non-Normal No.   Non-Normal No.				-	-	-	-
March   Marc	89335	Cryopreserve Testicular Tiss	review.	-	-	-	-
Manual	89337	Cryopreservation Oocyte(S)	predetermination to avoid post-service review.	OB402.023	Services for Infertility and Recurrent Fetal Loss	-	-
with window with a property of the property of	89342	Storage/Year Embryo(S)	review.	-	-	-	-
Mary	89343	Storage/Year Sperm/Semen		-	-	-	-
500         Signification         Month of School Control Con	89344	Storage/Year Reprod Tissue		_	-	-	_
	89346	Storage/Year Oocyte(S)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
March   Marc	89398	Unlisted Reprod Med Lab Proc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
		<u> </u>			Autism Spectrum Disorders (ASD)	-	-
Market   M							-
Michael   Mich			Prior Authorization per contract agreement.			-	-
No.	90378	Rsv Mab Im 50Mg	Prior Authorization per contract agreement.	RX504.009	Respiratory Syncytial Virus (RSV) Immunoprophylaxis	-	-
Second   S	90399	Immune Globulin	contract/clinical review.	-	-	-	-
Manual   M	90626	Tic-Brn Enceph Vac 0.25Ml Im		-	-	7/1/2021	-
Section   Process	90627	Tic-Brn Enceph Vac 0.5Ml Im		-	-	7/1/2021	-
	90666	Flu Vac Pandem Prsrv Free Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
Note   Property   Pr	90667	liv Vacc Pandemic Adiuvt Im	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_		_
	90669			_	<u>-</u>		-
Professional Pro				-	-	-	-
No.			review.	-	-		-
Second	90677	Pcv20 Vaccine Im	review.	-	-	7/1/2021	9/30/2021
Second	90749	Vaccine Toxoid	contract/clinical review.	_	-	-	-
Part	90867	Tcranial Magn Stim Tx Plan		PSY301.015	Repetitive Transcranial Magnetic Stimulation (rTMS)	_	_
Page	90868	Tcranial Magn Stim Tx Deli		PSY301.015	Repetitive Transcranial Magnetic Stimulation (rTMS)	_	_
Part	90869	Tcran Magn Stim Redetemine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	PSY301.015	Repetitive Transcranial Magnetic Stimulation (rTMS)	=	_
Part			Prior Addiorization per contract agreement.				
Process   Proc							
Product   Prod	90875	Psychophysiological Therapy				-	-
Part				PSY301.011	Neurofeedback		
Prince provide the provide provide the provide provide the provide pro				PSY301.018	Biofeedback as a Treatment of Chronic Pain		
Position			MD Colombia Providence for a for any formation and any loss Modified Politics Colombia Colombia				
Property	90876	Psychophysiological Therapy				-	-
Page 1 Pa				PSY301.011	Neurofeedback		
Procedure for the code positive reviews.  Note Control for Code place that the code positive reviews.  Personation of Record  Note Control for Code place the Control for Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part Plan. Not subject to pre-service review.  Personation of Record Part P	90880	Hypnotherapy		MED205.022	Treatment of Tinnitus		
Pegaration of Report  Non Control CP Procedum/service not covered by the Plan. Not subject to pre-service  Pegaration of Report  Non Control CP Procedum/service not specifically defined or classified, maybe subject to contract/clinical review.  Post of Procedum/service reviewed against Medical Policy Criteria. Submit of		.,,,,,		MED201.001	Hypnosis		
Polything of the product from the produc	90885	Des Franklan Of Deserts	predetermination to avoid post-service review.	MED201.001	Hypnosis	-	-
position of the properties of		<u> </u>	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MED201.001	Hypnosis –	-	-
Bileedback Train Any Met Parlieric Procedura/facrice reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  We pr	90889	<u> </u>	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MED201.001	Hypnosis	-	-
Spoke   Borkedback Train Any Welf   Borkedback Principle Previewed against Medical Policy Cirter's Submit for Principle Provider's Procedure's Proce	90889	Preparation Of Report	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	- -	- - -	-	- - -
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9991 8th Fraining 15 to Mine predetermination to avoid post-service review. PSY301.016 Bioleceback as a Treatment of Unianary incontinence 4/1/021	90899	Preparation Of Report  Psychiatric Service/Therapy	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- - - - - - - - - - - - - - - - - - -	Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Vieadache Biofeedback as a Treatment of Urinary Incontinence Biofeedback or Miscellaneous Indications	-	-
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Fig. 1913   Fig. 1	90899 90901 90912 90913 90999 91034 91035	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test  G-Esoph Reflx Tst W/Electrod	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed.	PSY301.018 PSY301.017 PSY301.017 PSY301.016 PSY301.001 PSY301.011 PSY301.011 PSY301.016 PSY301.016 PSY301.016 PSY301.016 PSY301.016  MED201.005	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 Uniany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence  Esophageal pH Monitoring Esophageal pH Monitoring		- - - - - - -
Breath Hydrogen/Methane Test   Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy   MED207.151   Hydrogen or Methane Breath Testing   Hydrogen Interviled	90899 90901 90912 90913 90999 91034 91035 91037	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed.  MP Criteria: Procedure/service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.017 PSY301.019 PSY301.016 PSY301.011 MED205.022 PSY301.011 MED201.016 PSY301.017 PSY301.016 PSY301.017 MED201.005 MED201.005	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 Uniany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence Biofeedback as a Treatment of Uniany Incontinence  B		- - - - - - -
9110 Gi Tract Capsule Endoscopy  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  9111 Esophageal Capsule Endoscopy  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).  610 Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9112 Eliu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  9113 Electrogastrography  610 Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9114 Saftonia Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9115 Saftonia Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9116 Saftonia Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9117 Saftonia Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  9118 Supplied Endoscopy (WCE)	90899 90901 90912 90913 90999 91034 91035	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  NP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.018 PSY301.017 PSY301.017 PSY301.019 PSY301.016 PSY301.011 MED205.022 PSY301.011 MED201.016 PSY301.017 PSY301.016 PSY301.017 MED201.005 MED201.005	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 Uniany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence Biofeedback as a Treatment of Uniany Incontinence  B		- - - - - - - - - -
Federal Endoscopy   Fede	90899 90901 90912 90913 90999 91034 91035 91037	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test  G-Esoph Refix Tst W/Electrod  Esoph Imped Function Test  Esoph Imped Funct Test > 1Hr	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined policy Criteria. Submit for predetermination to avoid post-service review.		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 Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence  Esophageal pH Monitoring Esophageal pH Monitoring Esophageal pH Monitoring		- - - - - - - - - -
### 150 Pages   Capsule Endoscopy   Check EU policy (PCP028, which is one of our Clinical Payment and Coding Policy	90899 90901 90912 90913 90999 91034 91035 91037 91038 91065	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test  Esoph Imped Function Test  Esoph Imped Function Test	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed.  MP Criteria: Procedure/service not reviewed against Medical Policy Criteria. Submit for Predetermination to avoid post-service reviewed.		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 Uniany Incontinence Biofeedback as a Treatment of Indiany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence		- - - - - - - - - -
EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.    Flu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	90899  90901  90912  90913  90999  91034  91035  91037  91038  91065	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test  Esoph Imped Function Test  Esoph Imped Function Test	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Ell: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service reviewemen.  Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service reviewemen.	PSY301.018 PSY301.017 PSY301.017 PSY301.019 PSY301.016 PSY301.011 MED205.022 PSY301.017 PSY301.016 PSY301.016 PSY301.016 PSY301.017 PSY301.016 PSY301.016 MED201.005 MED201.005 MED201.005 MED201.005 MED201.005 MED201.005	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 Headache Biofeedback as a Treatment of Uniany Incontinence Biofeedback or Miscellaneous Indications Neurofeedback Treatment of Tinnitus Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Uni		- - - - - - - - - - -
(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  91132 Electrogastrography Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy MED201.017 Gastrointestinal (GI) Motility Measurement	90899 90901 90912 90913 90999 91034 91035 91037 91038 91065	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test Esoph Imped Funct Test > 1Hr  Breath Hydrogen/Methane Test Gi Tract Capsule Endoscopy	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service reviewed.  BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	PSY301.018 PSY301.017 PSY301.017 PSY301.019 PSY301.016 PSY301.011 MED205.022 PSY301.017 PSY301.016 PSY301.016 PSY301.016 PSY301.017 PSY301.016 PSY301.016 MED201.005 MED201.005 MED201.005 MED201.005 MED201.005 MED201.005	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 Headache Biofeedback as a Treatment of Uniany Incontinence Biofeedback or Miscellaneous Indications Neurofeedback Treatment of Tinnitus Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Fecal Incontinence  Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Uni		
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(CPCP).	90899  90901  90912  90913  90999  91034  91035  91037  91038  91065	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test  Esoph Imped Funct Test > 1Hr  Breath Hydrogen/Methane Test Gi Tract Capsule Endoscopy  Esophageal Capsule Endoscopy	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		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 Headache Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Trianitus Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence  Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence Biofeedback as a Treatment of Uniany Incontinence  Esophageal pH Monitoring Esophageal pH Monitoring Esophageal pH Monitoring  Hydrogen or Methane Breath Testing  Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon		
	90899 90901 90912 90913 90999 91034 91035 91037 91038 91065 91110	Preparation Of Report  Psychiatric Service/Therapy  Biofeedback Train Any Meth  Bfb Training 1St 15 Min  Bfb Training 1St 15 Min  Bfb Training Ea Addl 15 Min  Dialysis Procedure  Gastroesophageal Reflux Test  G-Esoph Reflx Tst W/Electrod  Esoph Imped Function Test  Esoph Imped Function Test  Esoph Imped Function Test  Gi Tract Capsule Endoscopy  Esophageal Capsule Endoscopy  Gi Wireless Capsule Measure	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Elli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Elli: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check Ell policy CPCP028, 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.  Ell: Procedure/service not reimbursed by the Plan. Not subject		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 Ireadache Biofeedback as a Treatment of Irinary Incontinence Biofeedback as a Treatment of Irinary Incontinence Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Urinary Incontinence Biofeedback as a Treatment of Urinary Incontinence Biofeedback as a Treatment of Urinary Incontinence  Esophageal pH Monitoring Esophageal pH Monitoring Esophageal pH Monitoring  Esophageal pH Monitoring  Hydrogen or Methane Breath Testing  Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon  Gastrointestinal (Gi) Motility Measurement		

01122	Electrogock	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	MEDICA CAT	Cartesistantian (C) Matility Manager		
91133	Electrogastrography W/Test	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	MED201.017	Gastrointestinal (GI) Motility Measurement	-	-
91299	Gastroenterology Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service.	-	-	-	-
92015	Determine Refractive State	review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	-
92132	Cmptr Ophth Dx Img Ant Segmt	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.021	Optical Coherence Tomography of the Anterior Eye Segment	-	-
92145	Corneal Hysteresis Deter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.031	Corneal Hysteresis	-	-
92340	Fit Spectacles Monofocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	-
92341	Fit Spectacles Bifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
92342	Fit Spectacles Multifocal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
92354	Fit Spectacles Single System	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
92355	Fit Spectacles Compound Lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
92370	Repair & Adjust Spectacles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
92499	Eye Service Or Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
92512	Nasal Function Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED204.004	Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry		
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		Kninomanometry, Acoustic Kninometry, Optical Kninometry and Acoustic Pharyngometry	-	-
92517	Vemp Test I&R Cervical	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 review.	MED201.047	Vestibular Function Testing	5/15/2021	-
92518	Vemp Test I&R Ocular	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	5/15/2021	-
92519	Vemp Tst I&R Cervical&Ocular	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.047	Vestibular Function Testing	5/15/2021	-
92548	Cdp-Sot 6 Cond W/I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	-	-
92549	Cdp-Sot 6 Cond W/I&R Mct&Adt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.026	Dynamic Posturography	-	-
92700	Ent Procedure/Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
93050	Art Pressure Waveform Analys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED202.070	Non-invasive Measurement of Central Blood Pressure (cBP)	_	_
		(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm		
93228	Remote 30 Day Ecg Rev/Report	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003	Event Monitors, and Intracardiac Ischemia Detection Systems)  Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm	_	_
93229	Remote 30 Day Ecg Tech Supp	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003	Event Monitors, and Intracardiac Ischemia Detection Systems)	_	-
93264	Rem Mntr Wrls P-Art Prs Snr	predetermination to avoid post-service review.  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	_	-
93580	Transcath Closure Of Asd	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.024	Closure Devices for Patent Foramen Ovale and Atrial Septal Defects	-	_
93660	Tilt Table Evaluation	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	MED202.048	Tilt Table Testing	-	-
93702	Bis Xtracell Fluid Analysis	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.036	Bioimpedance Devices for Detection and Management of Lymphedema	-	-
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.014	Thermography	-	-
93799	Cardiovascular Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
93895	Carotid Intima Atheroma Eval	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD602.018	Ultrasonographic Measurement of Carotid Intima-Medial Thickness (CIMT) as an Assessment of Subclinical Atherosclerosis	_	-
93998	Noninvas Vasc Dx Study Proc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	-
94014	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	-	-
94015	Patient Recorded Spirometry	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.040	Home Spirometry	_	-
94016	Review Patient Spirometry	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.040	Home Spirometry	-	-
94452	Hast W/Report	(CPCP).  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
94453	Hast W/Oxygen Titrate	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_	_
94799	Pulmonary Service/Procedure	review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				_
95060	Eye Allergy Tests	contract/clinical review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED206.001	- Allergy Management	-	
95065	Nose Allergy Test	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	PSY301.014 MED206.001	Autism Spectrum Disorders (ASD)  Allergy Management		
95199	Allergy Immunology Services	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to	PSY301.014	Autism Spectrum Disorders (ASD)	_	_
95803	Actigraphy Testing	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.048	Actigraphy	_	_
95905	Motor &/ Sens Nrve Cndj Test	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED205.033	Automated Point-of-Care Nerve Conduction Testing	-	-
95961	Electrode Stimulation Brain	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.011	Intraoperative Neurophysiologic Monitoring (IONM)		
95962	Electrode Stim Brain Add-On	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.009 MED205.011	Topographic Brain Mapping (Quantitative Electroencephalography) Intraoperative Neurophysiologic Monitoring (IONM)	-	_
95962		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.009 PSY301.014	Topographic Brain Mapping (Quantitative Electroencephalography)  Autism Spectrum Disorders (ASD)	-	_
	Meg Spontaneous	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 95967	Meg Evoked Single  Meg Evoked Each Addl	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)	-	-
	· · · · · · · · · · · · · · · · · · ·	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RAD601.038	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	-	<u>-</u>
95980	Io Anal Gast N-Stim Init	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.031	Gastric Electrical Stimulation (GES)	-	-
95981	Io Anal Gast N-Stim Subsq	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR709.031	Gastric Electrical Stimulation (GES)	-	_
95982	Io Ga N-Stim Subsq W/Reprog	predetermination to avoid post-service review.	SUR709.031	Gastric Electrical Stimulation (GES)	_	_

95999	Neurological Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
96000	Motion Analysis Video/3D	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.009	Gait Analysis	_	_
96001	Motion Test W/Ft Press Meas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.009	Gait Analysis		
		predetermination to avoid post-service review.  MD Criteria: Precedure (continued against Medical Policy Criteria: Submit for	THE803.009	Gait Analysis		
96002	Dynamic Surface Emg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	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	_	
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE803.009	Gait Analysis		
96004	Phys Review Of Motion Tests	predetermination to avoid post-service review.	MED205.006	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, maybe subject to contract/clinical review.	_	-	_	_
96549	Chemotherapy Unspecified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
96571	Photodynamic Tx Addl 15 Min	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.029	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus		
96912	Photochemotherapy With Uv-A	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
96913	Photochemotherapy Uv-A Or B	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	THE801.033	Phototherapy for Dermatologic Conditions	-	-
96999	Dermatological Procedure	contract/clinical review.	-	-	-	-
97024	Diathermy Eg Microwave	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	THE803.008 THE803.010	Non Covered Physical Therapy Services Physical Therapy (PT) and Occupational Therapy (OT) Services	_	6/20/2021
		(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)		
97039	Physical Therapy Treatment	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	-	_
97139	Physical Medicine Procedure	contract/clinical review.	-	-	-	-
97169	Athletic Trn Eval Low Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
97170	Athletic Trn Eval Mod Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
97171	Athletic Trn Eval High Cmplx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
97172	Athletic Trn Re-Eval Plan Cr	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_			
97533		review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)		
37333	Sensory Integration	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	THE803.020	Sensory Integration Therapy and Auditory Integration Therapy	-	
97610	Low Frequency Non-Thermal Us	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.044	Ultrasound Wound Therapy	-	-
97799	Physical Medicine Procedure	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
97810	Acupunct W/O Stimul 15 Min	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	_
97811	Acupunct W/O Stimul Addl 15M	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	_
97813	Acupunct W/Stimul 15 Min	review.	-	-	-	-
97814	Acupunct W/Stimul Addl 15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
99024	Postop Follow-Up Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
99026	In-Hospital On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
99027	Out-Of-Hosp On Call Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
99050	Medical Services After Hrs	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
99056	Med Service Out Of Office	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
99058	Office Emergency Care	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		
		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
99070	Special Supplies Phys/Qhp	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
99071	Patient Education Materials	review.	_	-	-	_
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
99078	Group Health Education	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
99080	Special Reports Or Forms	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
99082	Unusual Physician Travel	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
99183		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	THE801.003	- Hyperbaric Oxygen (HBO2) Therapy		
	Hyperbaric Oxygen Therapy	Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	THE801.003	пурегранс охуден (пвог) тнегару	_	_
99199	Special Service/Proc/Report	contract/clinical review.	_	-	-	-
99429	Unlisted Preventive Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
99439	Chrnc Care Mgmt Svc Ea Addl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	1/1/2021	_
99446	Ntrprof Ph1/Ntrnet/Ehr 5-9	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2021
99447	Ntrprof Ph1/Ntrnet/Ehr 11-19	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	12/31/2021
99448	Ntrprof Ph1/Ntrnet/Ehr 21-29	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	12/31/2021
99449	Ntrprof Ph1/Ntrnet/Ehr 31/>	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				12/31/2021
99450		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	, ,
	Basic Life Disability Exam	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		-	-
99451	Ntrprof Ph1/Ntrnet/Ehr 5/>	review.	-	-	-	12/31/2021
99452	Ntrprof Ph1/Ntrnet/Ehr Rfrl	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
99453	Rem Mntr Physiol Param Setup	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
99454	Rem Mntr Physiol Param Dev	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
99455	Work Related Disability Exam	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
99456	Disability Examination	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	
99457	Rem Physiol Mntr 1St 20 Min	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-	
99458	Rem Physiol Mntr Ea Addl 19	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
99487	Cplx Chrnc Care 1St 60 Min	review.	-	-	-	-

99489	Cplx Chrnc Care Ea Addl 29	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
99490	Chrnc Care Mgmt Svc 1St 19	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
99491	Chrnc Care Mgmt Svc 30 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
99499	Unlisted E&M Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
99509	Home Visit Day Life Activity	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_			_
	,	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
99600	Home Visit Nos	contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	-
0052U	Lpoprtn Bld W/5 Maj Classes	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	-	-
0054T	Bone Srgry Cmptr Fluor Image	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	-	-
0055T	Bone Srgry Cmptr Ct/Mri Imag	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.023	Computer-Assisted Navigation for Orthopedic Procedures	-	-
0062U	Ai Sle Igg&Igm Alys 80 Bmrk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED207.159	Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Disease	s _	-
0063U	Neuro Autism 32 Amines Alg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
0066U	Pamg-1 la Cervico-Vag Fluid	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	OB401.018	Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy		_
00757	David Charak (Charak ) (and And	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	CUDZO4 O44	Forders and the Whose In Control of the Prince and I Market and Advance Discovery		
0075T	Perq Stent/Chest Vert Art	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	-	
0076T	S&I Stent/Chest Vert Art	predetermination to avoid post-service review.	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease	-	-
0097U	Gi Pathogen 22 Targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED207.155	Gastrointestinal Panels	-	-
0100T	Prosth Retina Receive&Gen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	-	-
0101T	Extracorp Shockwv Tx Hi Enrg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
0102T	Extracorp Shockwv Tx Anesth	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	_
0106T	Touch Quant Sensory Test	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED205.030	Quantitative Sensory Testing	_	_
0106U	Gstr Emptg 7 Timed Brth Spec	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED201.017	Gastrointestinal (GI) Motility Measurement		
0107T	Vibrate Quant Sensory Test	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED205.030	Quantitative Sensory Testing		
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	-
0108T	Cool Quant Sensory Test	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 review.	MED205.030	Quantitative Sensory Testing	-	-
0109T	Heat Quant Sensory Test	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 review.	MED205.030	Quantitative Sensory Testing	-	-
0110T	Nos Quant Sensory Test	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 review.	MED205.030	Quantitative Sensory Testing	-	-
0111T	Rbc Membranes Fatty Acids	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	-	12/31/2020
0139U	Neuro Austm Meas 6 C Metablt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	PSY301.014	Autism Spectrum Disorders (ASD)	-	9/30/2021
0184T	Exc Rectal Tumor Endoscopic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.040	Transanal Endoscopic Microsurgery	_	-
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 CPCP028, which is one of our Clinical Payment and Coding Policy	OTH903.022	Ophthalmologic Techniques For Evaluating Glaucoma	-	-
0200T	Perq Sacral Augmt Unilat Inj	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.056	Percutaneous Vertebroplasty and Sacroplasty	-	-
0201T	Perq Sacral Augmt Bilat Inj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RAD601.056	Percutaneous Vertebroplasty and Sacroplasty	_	_
0202T	Post Vert Arthrplst 1 Lumbar	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR712.034	Facet Arthroplasty	-	-
0207T	Clear Eyelid Gland W/Heat	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	OTH903.025	Eyelid Thermal Pulsation	_	_
0213T	Njx Paravert W/Us Cer/Thor	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR702.015	Facet Joint Injections		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
0214T	Njx Paravert W/Us Cer/Thor	Prior Authorization per contract agreement.	SUR702.015	Facet Joint Injections	-	-
0216T	Njx Paravert W/Us Lumb/Sac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR702.015	Facet Joint Injections	-	-
0217T	Njx Paravert W/Us Lumb/Sac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR702.015	Facet Joint Injections	_	-
0219T	Plmt Post Facet Implt Cerv	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	-	-
0220T	Plmt Post Facet Implt Thor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	-	-
0221T	Plmt Post Facet Implt Lumb	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR712.032	Isolated Facet Joint Fusion	-	-
0222T	Plmt Post Facet Implt Addl	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR712.032	Isolated Facet Joint Fusion	-	_
0232T	Njx Platelet Plasma	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	RX501.101 RX501.034	Orthopedic Applications of Platelet-Rich Plasma Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-	-	_
0253T	Insert Aqueous Drain Device	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Orthopedic Conditions  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 CPCP028, which is one of our Clinical Payment and Coding Policy	SUR703.051 SUR703.048	Orthopedic Applications of Stem-Cell Therapy Stem Cell Therapy for Peripheral Arterial Disease (PAD)	-	-
		(CPCP).				

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	SUR703.051	Orthopedic Applications of Stem-Cell Therapy		
0264T	Im B1 Mrw Cel Ther Xcl Hrvst	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR703.048	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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	-	-
0308T	Insj Ocular Telescope Prosth	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_
0312T	Laps Impltj Nstim Vagus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	_
0313T	Laps Rmvl Nstim Array Vagus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	_
0314T	Laps Rmvl Vgl Arry&Pls Gen	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	2/15/2021	
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR701.039			-
0315T	Rmvl Vagus Nerve Pls Gen	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Vagus Nerve Blocking Therapy for Treatment of Obesity	-	-
0316T	Replc Vagus Nerve Pls Gen	Prior Authorization per contract agreement.	SUR701.039	Vagus Nerve Blocking Therapy for Treatment of Obesity	-	-
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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	-	-
0331T	Heart Symp Image Plnr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD604.012	Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure	4/1/2021	-
0332T	Heart Symp Image Plnr Spect	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	_	_
0335T	Insj Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.027	Subtalar Arthroereisis (STA)		
	, , , , , , , , , , , , , , , , , , , ,	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				-
0338T	Trnscth Renal Symp Denrv Unl	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 review.	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0339Т	Trnscth Renal Symp Denrv Bil	Check EU 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 review.	SUR701.030	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	-	-
0347T	Ins Bone Device For Rsa	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0348T	Rsa Spine Exam	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, 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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.054	Radiostereometric Analysis for Assessment of Orthopedic Implant Position	-	-
0352T	Oct Brst/Node I&R Per Spec	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RAD601.053	Optical Coherence Tomography of the Breast	-	-
0354T	Oct Breast Surg Cavity I&R	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	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 CPCP028, which is one of our Clinical Payment and Coding Policy	RAD601.042	Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon		
03331	or muce capsure Endoscopy	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	-
0356T	Insrt Drug Device For Iop	predetermination to avoid post-service review.	OTH903.024	Intravitreal, Punctum and Intracameral Implants	-	_
0358T	Bia Whole Body	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.045	Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA)	-	-
0376T	Insert Ant Segment Drain Int	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	-
0378T	Visual Field Assmnt Rev/Rprt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	-	-
0379T	Vis Field Assmnt Tech Suppt	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.044	Home-Based Monitoring of Visual Field	-	-
0396Т	Intraop Kinetic Balnce Sensr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	-	12/31/2020
0397T	Ercp W/Optical Endomicroscpy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.038	Confocal Laser Endomicroscopy (CLE)	-	-
0398T	Mrgfus Strtctc Les Abltj	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.022	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)	_	_
0408T	Insj/Rplc Cardiac Modulj Sys	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.068	Cardiac Contractility Modulation (CCM) Device		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR710.024	Aquablation of the Prostate	_	
0421T	Waterjet Prostate Abltj Cmpl	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
0422T	Tactile Breast Img Uni/Bi	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	RAD602.019	Elastography	-	-
0423T	Assay Secretory Type Ii Pla1	Check EIU policy CPCP028, 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea	-	-
0434T	Interro Eval Npgs Apnea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.042	Phrenic Nerve Stimulation for Central Sleep Apnea		-
0441T	Abitj Perc Lxtr/Perph Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.035	Percutaneous Image-Guided Nerve Cryoablation for Phantom Limb Pain (PLP)	_	-
0442T	Abitj Perc Plex/Trnci Nrv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.035	Percutaneous Image-Guided Nerve Cryoablation for Phantom Limb Pain (PLP)	-	-
0444T	Oth Plmt Drug Elut Oc Ins	predetermination to avoid post-service review.  EIU: Procedure/Service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	-
0445T	Sbsqt Plmt Drug Elut Oc Ins	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.035	Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts	-	-
0449T	Insj Aqueous Drain Dev 1St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma	_	_
0450T	Insj Aqueous Drain Dev Each	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034	Aqueous Shunts and Stents for Glaucoma	5/1/2021	12/31/2999
0450T	Remyl Aortic Ventr Cmpl Sys	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017			,,
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Ventricular Assist Devices and Total Artificial Hearts	-	-
0462T 0464T	Prgrmg Eval Aortic Ventr Sys  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 CPCP028, which is one of our Clinical Payment and Coding Policy	SUR707.017 OTH903.033	Ventricular Assist Devices and Total Artificial Hearts  Visual Evoked Potential Testing for Glaucoma	-	-
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	-
0465T	Supchrdl Njx Rx W/O Supply	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.035	Suprachoroidal Injection of a Pharmacologic Agent	-	-

Section   Sect							
Second	0466T	Insj Ch Wal Respir Eltrd/Ra		SUR706.009	Sleep Related Breathing Disorders: Surgical Management	-	-
See	0467T	Revj/Rplmnt Ch Respir Eltrd		SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
	0468T	Rmvl Ch Wal Respir Eltrd/Ra	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR706.009	Sleep Related Breathing Disorders: Surgical Management	_	_
Part	0472T	Prgrmg Io Rta Eltrd Ra	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR713.026	Retinal Prosthesis	_	_
See the second process of the second process	0473T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR713.026	Retinal Prosthesis	_	-
March   Marc	0474T	Insi Aqueous Dra Dev Io Rsyr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713 034	Anuenus Shunts and Stents for Glauroma		
Section   Company   Comp						-	
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Series of the control	0483T		predetermination to avoid post-service review.	SUR707.025		-	_
Second	0485T		Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046		-	-
Mark   1908	0486T	Oct Mid Ear I&R Bilateral	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.046		-	-
Control   Cont	0493T	Near Ifr Spectrsc Of Wounds	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.006	Foot Care Services	-	-
Second   S	0499T	Cysto F/Urtl Strix/Stenosis	Check EIU policy CPCP028, 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	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.025	Eyelid Thermal Pulsation	-	-
	0508T		Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RAD601.071	Pulse-Echo Ultrasound Bone Density Measurement	-	-
Second   Process   Proce	0509T		Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OTH903.036		5/15/2021	-
Section   Process   Proc	0510T	Rmvl Sinus Tarsi Implant		SUR705.027	Subtalar Arthroereisis (STA)	-	_
Second State   1985	0511T	Rmvl&Rinsj Sinus Tarsi Implt	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.027	Subtalar Arthroereisis (STA)	-	-
	0512T		Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.018	prop:eq:extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
	0513T	Esw Integ Wnd Hlg Ea Addl	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.018	Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries	-	-
Part   Content   Part	0516T	Insj Wcs Lv Eltrd Only		MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	-	_
	0517T	Insj Wcs Lv Pg Compnt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	_	_
Part	0524T	Ev Cath Dir Chem Abltj W/Img	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management	_	_
Part	0529T	Interrog Dev Eval lims Ip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003		_	
Company   Comp	0533T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED205.041		_	_
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State   1	0535T	Cont Rec Mvmt Do Reprt Cnfig	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices		_
Mart Call Pix Morting   Control Processing Services	0536T		${\bf EIU: Procedure/service\ not\ reimbursed\ by\ the\ Plan.\ Not\ subject\ to\ pre-service\ review}.$	MED205.041	Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices	_	-
Fig. 12 Fig. 1	0547T	P1 Matri Qual Tet Merind Tih					
Company   Comp			EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	SUR701.036	Implanted Adjustable Continence Therapy		_
SELF   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service not rembursed by the Plan. Not subject to pre-service review.   Service   Procedur/service review of confidence   Procedur/service   Procedur/service review of confidence   Procedur/service   Procedu			(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
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Sear Melbomian Gind Heat Bill   Check Ell Upolicy CFRD28, which is one of our Clinical Payment and Coding Policy   OTHorogatic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used   Afs/2001   8/14/2021	0551T		(CPCP).	SUR701.036	Implanted Adjustable Continence Therapy	-	-
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Sefect   Procedure/Service reviews   Substitute   Procedure/Service reviews			(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used		8/14/2021
MeDia   Medi			EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy		Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used		-
Revision/Removal Isdns Ptn MP Citteria: Procedure/service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Procedure/service reviewed.  MB Citteria: Procedure/service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predetermination to avoid post-service reviewed.  MB Citteria: Submit for predatermination to avoid post-service reviewed.  MB Citteria: Submit for predatermination to avoid post-service reviewed.  MB Citteria: Submit for predatermination to avoid post-service review.  MB Citteria: Submit for preda	0587T	Perg Impltj/Rolcmt Isdns Ptn	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED205.035		3/1/2021	
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predetermination to avoid post-service review.  MED205.035 Percutaneous Initial Nerve Stimulation (PTNS) 3/1/2021   MED205.035 Percutaneous In							-
Percentage   Per			predetermination to avoid post-service review.				-
Transdermal Gfr Measurements   Check Elly policy CPCP028, which is one of our Clinical Payment and Coding Policy   MED201.050   Transdermal Glomerular Filtration Rate   4/1/2021   CPCP).   CPCP).   CPCPD.   C	U59U f	LIEC Alys Cplx Prgrmg lins	predetermination to avoid post-service review.	MED205.035	rercutaneous Tibial Nerve Stimulation (PTNS)	3/1/2021	-
663T Transdermal Gfr Monitoring Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Transdermal Glomerular Filtration Rate 4/1/201	0602T		Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.050	Transdermal Glomerular Filtration Rate	4/1/2021	-
615T Eye Mvmt Alys W/O Calbrj 1&R Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy ADM1001.032 Experimental, Investigational and/or Unproven Procedures/Services 5/15/2021 _	0603T	Transdermal Gfr Monitoring	Check EIU policy CPCP028, 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	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-

Section   Sect	осрот						
The second of th	06201	Evasc Ven Artiz Tibl/Prnl Vn		ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Second   Company   Compa	0621T	Trabeculostomy Interno Laser	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Section   Sect	0622T	Trabeculostomy Int Lsr W/Scp	$\hbox{EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review}.$	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_
	0623T	Auto Quantification C Plaque	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services		
			(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	-
	06241	Auto Quan C Plaq Data Prep	(CPCP).	ADM1001.032	Experimental, investigational and/or Unproven Procedures/Services	-	-
Seek of Seek o	0625T	Auto Quan C Plaq Cptr Alys	(CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Second   Second Process   Second Proce	0626T	Auto Quan C Plaq I&R	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Part	0627T	Perq Njx Algc Fluor Lmbr 1St	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
1985   1985	0628T	Perq Njx Algc Fluor Lmbr Ea	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Part	0629T	Perq Njx Algc Ct Lmbr 1St	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Part	0630T	Perq Njx Algc Ct Lmbr Ea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	_	_
	0624T		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	ADM1001 022	Functional to Investigations and for University Described Function		
Company	06311	To vis Lit Hyperspectral Img	(CPCP).	ADM1001.032		-	-
Second   S	0632T	Perq Tcat Us Abltj Nrv P-Art	(CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
March   Marc	0639T	Wrls Skn Snr Anisotropy Meas	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	-	-
Month   Mont	0640T	Nente Nr Ifr Spetrse Wnd	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
Part	0641T	Nente Nr Ifr Spetrse Wnd Img	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
Section   Part	0642T	Ncntc Nr Ifr Spctrsc Wnd I&R	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	-
	0643T	Tcat L Ventr Rstrj Dev Implt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	7/1/2021	_
Part	0645T	Trat Impliti C Sins Rdcti Dev		ADM1001 032	Evnerimental Investigational and/or Unproven Procedures/Services	7/1/2021	
Page   10   10   10   10   10   10   10   1							
Part							
	0650T	Prgrmg Dev Eval Scrms Remote	predetermination to avoid post-service review.	MED202.003		7/1/2021	-
Content   Cont	0656T	Vrt Bdy Tethering Ant <7 Seg	Check EIU policy CPCP028, 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	-
Section 1 contribution of the contribution of	0657T	Vrt Bdy Tethering Ant 8+ Seg	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.046	Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis	7/1/2021	-
Sect	0664T	Don Hysterectomy Open Cdvr		OB402.023	Services for Infertility and Recurrent Fetal Loss	7/1/2021	8/14/2021
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Continue	0664T	Don Hysterectomy Open Cdvr	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	OB402.023	Services for Infertility and Recurrent Fetal Loss		12/31/2999
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A090 Interest Escort In Non Er  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Noner Transport Wheelch Van Romer Transport Wheelch Van Noner Transport Wheelch Van Noner Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Noner Transport Van Noner Transport Van Noner Van None Van Van None Van	0665T 0665T 0666T 0666T 0667T 0667T 0668T 0668T 0669T 0669T 0669T	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Bkbench Rcnstj Don Uter Artl	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP C	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
A0100 Nonemergency Transport Task A0100 Nonemergency Transport Bus Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	0665T 0665T 0666T 0666T 0667T 0667T 0668T 0668T 0669T 0669T 0670T 0670T A0021	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrit  Bkbench Prep Don Uter Algrit  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Bkbench Rcnstj Don Uter Artl  Bkbench Rcnstj Don Uter Artl  Outside State Ambulance Serv	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
A0110 Nonemergency Transport Bus Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0120 Noner Transport Mini-Bus Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0130 Noner Transport Wheelch Van Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0140 Nonemergency Transport Air Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0140 Nonemergency Transport Air Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	0665T 0665T 0666T 0666T 0666T 0667T 0667T 0668T 0668T 0669T 0669T 0670T 0670T A0021 A0080	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Uter Rcnstj Don Uter Artl  Uter Rcnstj Don Uter Artl  Outside State Ambulance Serv  Noninterest Escort In Non Er	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
A0120 Noner Transport Mini-Bus Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0130 Noner Transport Wheelch Van Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0130 Noner Transport Wheelch Van Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  A0140 Nonempreparty Transport Air Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	0665T 0665T 0666T 0666T 0666T 0667T 0667T 0668T 0668T 0669T 0669T 0670T 0670T A0021 A0080	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Outside State Ambulance Serv  Noninterest Escort in Non Er	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, w	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
A0130 Noner Transport Wheelch Van Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service	0665T 0665T 0666T 0666T 0666T 0667T 0668T 0668T 0669T 0670T 0670T A0021 A0080 A0090 A0100	Don Hysterectomy Open Liv Don Hysterectomy Open Liv Don Hysterectomy Laps Liv Don Hysterectomy Laps Liv Don Hysterectomy Laps Liv Don Hysterectomy Rcp Uter Don Hysterectomy Rcp Uter Bkbench Prep Don Uter Algrft Bkbench Prep Don Uter Algrft Bkbench Rcnstj Don Uter Ven Bkbench Rcnstj Don Uter Ven Bkbench Rcnstj Don Uter Artl Bkbench Rcnstj Don Uter Artl Uter Artl Bkbench Rcnstj Don Uter Artl Bkbench Rcnstj Don Uter Artl Bkbench Rcnstj Don Uter Artl Interest Escort in Non Er Interest Escort in Non Er	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteri	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
A0130 Nonem transport Wheelch Van review	0665T 0665T 0666T 0666T 0666T 0667T 0668T 0668T 0669T 0669T 0670T 0670T A0021 A0080 A0090 A0110	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Uter Artl  Uter Artl  Outside State Ambulance Serv  Noninterest Escort in Non Er  Interest Escort in Non Er  Nonemergency Transport Taxi  Nonemergency Transport Taxi	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EUL policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for prede	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
	0665T 0665T 0666T 0666T 0666T 0667T 0667T 0668T 0668T 0669T 0670T 0670T A0021 A0080 A0090 A0110 A0120	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Outside State Ambulance Serv  Noninterest Escort In Non Er  Interest Escort In Non Er  Nonemergency Transport Taxi  Nonemergency Transport Bus  Noner Transport Mini-Bus	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. EUL: Procedure/service not creviewed against	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021
	0665T 0665T 0666T 0666T 0666T 0667T 0668T 0668T 0669T 0669T 0670T 0670T A0021 A0080 A0090 A0110 A0120 A0130	Don Hysterectomy Open Liv  Don Hysterectomy Open Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Laps Liv  Don Hysterectomy Rcp Uter  Don Hysterectomy Rcp Uter  Bkbench Prep Don Uter Algrft  Bkbench Prep Don Uter Algrft  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Ven  Bkbench Rcnstj Don Uter Artl  Dkbench Rcnstj Don Uter Artl  Dutside State Ambulance Serv  Noninterest Escort in Non Er  Interest Escort in Non Er  Nonemergency Transport Taxi  Nonemergency Transport Bus  Noner Transport Mini-Bus  Noner Transport Mini-Bus	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EUL: Procedure/service not overed by the Plan. Not subject to pre-service review.  Non Covered: Procedu	OB402.023	Services for Infertility and Recurrent Fetal Loss  Services for Infertility and Recurrent Fetal Loss	8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021 8/15/2021 7/1/2021	8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021 12/31/2999 8/14/2021

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A0160	Noner Transport Case Worker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
A0170	Transport Parking Fees/Tolls	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
A0180	Noner Transport Lodgng Recip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
A0190	Noner Transport Meals Recip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
A0200	Noner Transport Lodgng Escrt	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		_
A0210	Noner Transport Meals Escort	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	_	
		review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	-	_
A0426	Als 0	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.005	Ambulance and Medical Transport Services	_	
A0428	Bls	predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	-	_
A0430	Fixed Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	ADM1001.005	Ambulance and Medical Transport Services	-	_
A0431	Rotary Wing Air Transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0435	Fixed Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0436	Rotary Wing Air Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.005	Ambulance and Medical Transport Services	_	_
A0888	Noncovered Ambulance Mileage	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_	
		review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM41001 00F	Applylance and Madical Transport Sonices	_	_
A0998	Ambulance Response/Treatment	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	ADM1001.005	Ambulance and Medical Transport Services	-	
A0999	Unlisted Ambulance Service	contract/clinical review.	-	-	-	_
A4267	Male Condom	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
A4290	Sacral Nerve Stim Test Lead	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018	Sacral Nerve Neuromodulation/Stimulation	-	_
A4335	Incontinence Supply	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
A4421	Ostomy Supply Misc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
A4458	Reusable Enema Bag	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
A4520	Incontinence Garment Anytype	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_		
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	
A4553	Nondisp Underpads All Sizes	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
A4554	Disposable Underpads	review.	-	-	-	_
A4555	Ca Tx E-Stim Electr/Transduc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.039	Tumor Treating Fields (TTF) Therapy	-	_
	Topical Hyperbaric Oxygen	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	PSY301.014	Autism Spectrum Disorders (ASD)		
A4575	Chamber Disposable	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). May require Prior Authorization per contract agreement	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
A4600	Sleeve Inter Limb Comp Dev	predetermination to avoid post-service review.	MED202.073	Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	
A4639	Infrared Ht Sys Replcmnt Pad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)		
		(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to				-
A4641	Radiopharm Dx Agent Noc	contract/clinical review.	-	-	-	-
A4649	Surgical Supplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
A4890	Repair/Maint Cont Hemo Equip	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
A4913	Misc Dialysis Supplies Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
A4927	Non-Sterile Gloves	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
A4931	Reusable Oral Thermometer	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		
A4932	Reusable Rectal Thermometer	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<del>-</del>		
		review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	_	_
A5507	Modification Diabetic Shoe	contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	_
A6000	Wound Warming Wound Cover	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.050	Noncontact Normothermic Wound Therapy		_
A6261	Wound Filler Gel/Paste /Oz	(CPCP).			-	
,10201		Unlisted: Procedure/service not specifically defined or classified, maybe subject to			-	
		contract/clinical review.	-	-	-	-
A6262	Wound Filler Dry Form / Gram	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
A6262 A6512		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- -	- - -	- - -	- -
	Wound Filler Dry Form / Gram	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	- - -	-	-
A6512	Wound Filler Dry Form / Gram Compres Burn Garment Noc	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	- - -		-	-
A6512 A6549	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking	contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service not covered by the Plan. Not subject to pre-service.	-		-	-
A6512 A6549 A9150	Wound Filler Dry Form / Gram  Compres Burn Garment Noc  G Compression Stocking  Misc/Exper Non-Prescript Dru	contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-	-
A6512 A6549 A9150 A9152 A9153	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos	contract/clinical review.  Unilstate: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstate: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstate: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstate: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-	-
A6512 A6549 A9150 A9152 A9153 A9270	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service	contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-		-	-
A6512 A6549 A9150 A9152 A9153 A9270 A9279	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		-	-
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unitsted: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-		-	
A6512 A6549 A9150 A9152 A9153 A9270 A9279	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc	contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unilsted: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unilsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-	
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc	contract/clinical review.  Unilstact: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstact: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstact: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unilstact: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unilstact: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280 A9282 A9285	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc Wig Any Type Inversion Eversion Cor Devic	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowerd: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not covered by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).			-	
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280 A9282 A9285 A9300	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc Wig Any Type Inversion Eversion Cor Devic Exercise Equipment	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Flu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check Elu Policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.				
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A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280 A9282 A9285 A9300	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc Wig Any Type Inversion Eversion Cor Devic Exercise Equipment	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  BIU: Procedure/service not covered by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  BIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCPO28, 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.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.				
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280 A9282 A9285 A9300 A9579	Wound Filler Dry Form / Gram Compres Burn Garment Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc Wig Any Type Inversion Eversion Cor Devic Exercise Equipment Gad-Base Mr Contrast Nos 1MI	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowerd: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU: Procedure/service not covered by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EU policy CPCPQ2, which is one of our Clinical Payment and Coding Policy (CPCP).  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.				
A6512 A6549 A9150 A9152 A9153 A9270 A9279 A9280 A9282 A9285 A9300 A9579 A9597	Wound Filler Dry Form / Gram Compres Burn Garment. Noc G Compression Stocking Misc/Exper Non-Prescript Dru Single Vitamin Nos Multi-Vitamin Nos Non-Covered Item Or Service Monitoring Feature/Devicenoc Alert Device Noc Wig Any Type Inversion Eversion Cor Devic Exercise Equipment Gad-Base Mr Contrast Nos 1MI Pet Dx For Tumor Id Noc	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  EIU- Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Cowered: Procedure/service not covered by the Plan. Not subject to pre-service review.  EIU- Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Leck EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  Non Cowered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.				
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A9999	Dme Supply Or Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
B4105	Enzyme Cartridge Enteral Nut	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.011	Nutritional Support	_	_
B9998	Enteral Supp Not Otherwise C	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
B9999	Parenteral Supp Not Othrws C	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
C1052	Hemostatic Agent Gi Topic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
C1761	Cath trans intra litho/coro	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	N/A	N/A	7/1/2021	_
C1764	Event Recorder Cardiac	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm	_	_
C1776	Joint Device (Implantable)	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.024	Event Monitors, and Intracardiac Ischemia Detection Systems)  Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee		
C1783		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.034		-	_
	Ocular Imp Aqueous Drain De	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Aqueous Shunts and Stents for Glaucoma	-	_
C1817	Septal Defect Imp Sys	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.024	Closure Devices for Patent Foramen Ovale and Atrial Septal Defects	-	_
C1818	Integrated Keratoprosthesis	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.030	Keratoprosthesis	-	_
C1825	Gen Neuro Carot Sinus Baro	predetermination to avoid post-service review.	THE801.034	Baroreflex Stimulation Devices	2/1/2021	-
C1841	Retinal Prosth Int/Ext Comp	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR713.026	Retinal Prosthesis	-	-
C1842	Retinal Prosth Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR713.026	Retinal Prosthesis	-	_
C1889	Implant/Insert Device Noc	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
	***	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease		
C2623	Cath Translumin Drug-Coat	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 Sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.058	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	-	_
C2698	Brachytx Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	-
C2699	Brachytx Non-Stranded Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
C9062	Daratumumab Hyaluronidase	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	N/A		12/31/2020
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	
C9064	Mitomycin Pyelocalyceal Inst	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	N/A	-	12/31/2020
C9066	Sacituzumab Govitecan-Hziy	Prior Authorization per contract agreement.	RX502.061	N/A	-	12/31/2020
C9072	Inj Imm Glob Asceniv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	2/1/2021	3/1/2021
C9073	Brexucabtagene Autoleucel Ca	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	2/1/2021	3/1/2021
C9074	Injection lumasiran	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	5/1/2021	_
C9075	Injection casimersen 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	N/A	N/A	7/1/2021	9/30/2021
C9076	Lisocabtagene car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	7/1/2021	9/30/2021
C9081	Idecabtagene Car Pos T	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	10/1/2021	_
C9257	Bevacizumab Injection	predetermination to avoid post-service review.  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	_	_
C9354	Veritas Collagen Matrix Cm1	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	OTH903.015 SUR704.012	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Bioengineered Skin and Soft Tissue Substitutes	-	-
C9356	Tenoglide Tendon Prot Cm1	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes		
	Dermal Substitute Native Non-	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		•		
C9358	Origin (Surgimend Collagen Matrix) Per 0.5 Square	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9359	Centimeters  Implnt bon void filler-putty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Authorogy Bone Marcon)	4/1/2021	_
		Prior Authorization per contract agreement. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		With Autologous Bone Marrow)		
C9360	Surgimend Neonatal	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
C9362	Implnt bon void filler-strip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR703.051	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	4/1/2021	_
C9363	Integra Meshed Bil Wound Mat	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
C9364	Porcine Implant Permacol	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes		
		(CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	- 51170-LOIE		-	-
C9399	Unclassified Drugs Or Biologicals	contract/clinical review.	-	-	-	-
C9734	U/S Trtmt Not Leiomyomata	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.022	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)	-	_
C9739	Cystoscopy Prostatic Imp 1-2	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH)		
C9740	Cysto Impl 4 Or More	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR710.023	Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH)	-	-
C9745	Nasal Endo Eustachian Tube	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	N/A	N/A	-	12/31/2020
C9747	Ablation Hifu Prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.014	High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer	_	12/31/2020
C9749	Repair Nasal Stenosis W/Imp	Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	N/A	N/A	-	12/31/2020
C9752	Intransseque des lumb (enerus	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.020	Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back	7/1/2021	
	Intraosseous des lumb/sacrum	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Pain Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back		-
C9753	Intraosseous destruct add'l	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR702.020	Pain	7/1/2021	-
C9764	Revasc Intravasc Lithotripsy	predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
C9765	Revasc Intra Lithotrip-Stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
C9766	Revasc Intra Lithotrip-Ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
C9767	Revasc Lithotrip-Stent-Ather	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	-
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C9768	Endo Us-Guide Hep Porto Grad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.043	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	-	2/28/2021
C9768	Endo Us-Guide Hep Porto Grad	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR701.043	Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement	3/1/2021	_
C9770	Vitrec/mech pars, subret inj	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.098	Gene Therapy for Inherited Retinal Dystrophy	4/1/2021	
		predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				-
C9771	Nsl/Sins Cryo Post Nasal Tis	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	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.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9772	Revasc Lithotrip Tibi/Perone	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9773	Revasc Lithotr-Stent Tib/Per	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9773	Revasc Lithotr-Stent Tib/Per	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	_
C9774	Revasc Lithotr-Ather Tib/Per	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9774	Revasc Lithotr-Ather Tib/Per	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	
		(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				-
C9775	Revasc Lith-Sten-Ath Tib/Per	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	5/15/2021	8/14/2021
C9775	Revasc Lith-Sten-Ath Tib/Per	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	8/15/2021	-
C9777	Esophag Mucosal Integ Add-On	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	ADM1001.032	EIU Procedures/Services	8/15/2021	12/31/2999
C9898	Inpnt Stay Radiolabeled Item	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
C9899	Inpt Implant Pros Dev No Cov	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to		_	_	_
D0999	Unspecified Diagnostic Procedure By Report	contract/clinical review.  • Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_		_	_
D1705	AstraZeneca Covid-19 vaccine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			8/15/2021	
51703	administration – first dose	review.	-		0,13,1011	-
D1706	AstraZeneca Covid-19 vaccine administration – second dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	3/15/2021	-
D1999	Unspecified Preventive Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	-
D2999	Unspecified Restorative Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
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, maybe subject to contract/clinical review.	-	-	-	-
D4999	Unspecified Periodontal Procedure By Report Unspecified Removable	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
D5899	Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
D5999	Unspecified Maxillofacial Prosthesis By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
D6199	Unspecified Implant Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
D6999	Unspecified Fixed Prosthodontic Procedure By Report	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
	Extraction Erupted Tooth Requiring Removal Of Bone					
D7210	And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D7220	Removal Of Impacted Tooth -	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
	Soft Tissue Removal Of Impacted Tooth -	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	<u>-</u>	-	-
D7230	Partially Bony Unspecified Oral Surgery	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	-	-
D8210	Procedure By Report  Removable Appliance Therapy	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_ <del>-</del>	-	-
D8220	Fixed Appliance Therapy	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_	_	_
D8999	Unspecified Orthodontic	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
D9995		contract/clinical review.  I- Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
	Time Encounter	review.	-		_	-
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist For Subsequent Review	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
D9999	Unspecified Adjunctive	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-	_
E0187	Procedure By Report  Water Pressure Mattress	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	_	_
E0210	Electric Heat Pad Standard	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	-
E0217	Water Circ Heat Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
E0218	Fluid Circ Cold Pad W Pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.045	Skin Contact Monochromatic Infrared Energy (MIRE)	-	-
E0231	Wound Warming Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.050	Noncontact Normothermic Wound Therapy	-	-
E0236	Pump For Water Circulating P	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0240	Bath/Shower Chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0241	Bath Tub Wall Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-

E0242	Bath Tub Rail Floor	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0243	Toilet Rail	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E0244	Toilet Seat Raised	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
E0247	Trans Bench W/Wo Comm Open	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
E0248	Hdtrans Bench W/Wo Comm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
E0273	Open Bed Board	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				_
E0274	Over-Bed Table	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		-
E0280	Bed Cradle	review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.001	- Hospital Beds and Related Equipment	-	-
E0290	Hosp Bed Fx Ht W/O Rails W/M	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DMF101.001	Hospital Beds and Related Equipment	-	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Hospital Beds and Related Equipment	_	-
E0292	Hosp Bed Var Ht No Sr W/Matt	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.001		_	_
E0293	Hosp Bed Var Ht No Sr No Mat	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	DME101.001	Hospital Beds and Related Equipment	-	-
E0315	Bed Accessory Brd/Tbl/Supprt	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
E0316	Bed Safety Enclosure	review.	-	-	-	-
E0372	Powered Air Mattress Overlay	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, maybe subject to contract/clinical review.	-	-	-	-
E0485	Oral Device/Appliance Prefab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	MED204.005	Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome	-	_
E0487	Electronic Spirometer	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.040	Home Spirometry	-	-
E0616	Cardiac Event Recorder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.003	Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)	-	-
E0617	Automatic Ext Defibrillator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.021	Nonwearable Automatic External Defibrillator (AED) for Home Use	_	-
E0625	Patient Lift Bathroom Or Toi	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
E0650	Pneuma Compresor Non-	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED202.060	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers		
EU65U	Segment	predetermination to avoid post-service review.	MED202.073	Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	
E0651	Pneum Compressor Segmental	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient 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 Outpatient 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 Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0656	Segmental Pneumatic Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0657	Segmental Pneumatic Chest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	_
E0660	Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	_
E0665	Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	
E0666	Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	
E0667	Seg Pneumatic Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	
E0668	Seg Pneumatic Appl Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0669	Seg Pneumatic Appli 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 Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0670	Seg Pneum Int Legs/Trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	-	-
E0671	Pressure Pneum Appl Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers Postsurgical Outpatient 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 Outpatient 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.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	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	-	-
E0675	Pneumatic Compression Device	Check EIU policy CPCP028, 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	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	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	-	-
E0691	Uvl Pnl 2 Sq Ft Or Less	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.033	Phototherapy for Dermatologic Conditions	-	-
E0692	Uvl Sys Panel 4 Ft	predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	_
E0693	Uvl Sys Panel 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	_
E0694	Uvl Md Cabinet Sys 6 Ft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE801.033	Phototherapy for Dermatologic Conditions	-	-
E0731	Conductive Garment For Tens/	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR)	-	_
E0740	Non-Implant Pelv Flr E-Stim	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	DME101.037 MED201.030	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence Sexual Dysfunctions, Assessment and Treatment	-	-
E0745	Neuromuscular Stim For Shock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR710.018 MED201.026	Sacral Nerve Neuromodulation/Stimulation Surface Electrical Stimulation	-	_
E0747	Elec Osteogen Stim Not Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR705.044	Electrical Bone Growth Stimulation of the Appendicular Skeleton	_	-

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E0760	Osteogen Ultrasound Stimltor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	DME101.030	Low Intensity Pulsed Ultrasound Fracture Healing Device	-	-
E0761	Nontherm Electromgntc Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	_
E0762	Trans Elec Jt Stim Dev Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.042	Electrical Stimulation for the Treatment of Arthritis	-	-
E0764	Functional Neuromuscularstim	EII: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). May require Prior Authorization per contract agreement	MED201.033	Functional Neuromuscular Electrical Stimulation	-	6/30/2021
E0765	Nerve Stimulator For Tx N&V	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR709.031	Gastric Electrical Stimulation (GES)	_	_
E0766	Elec Stim Cancer Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.039	Tumor Treating Fields (TTF) Therapy	_	_
E0769	Electric Wound Treatment Dev	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	-
		(CPCP).  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
E0770	Functional Electric Stim Nos	contract/clinical review. May require Prior Authorization per contract agreement.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	-
E0830	Ambulatory Traction Device	Check EIU policy CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.046	Traction Devices for Use in the Home	-	_
E0855	Cervical Traction Equipment	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.046	Traction Devices for Use in the Home	_	_
E0856	Cervic Collar W Air Bladders	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.041	Pneumatic Traction and Spinal Unloading Devices	_	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	DME101.046	Traction Devices for Use in the Home		
E0860	Tract Equip Cervical Tract	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 review.	DME101.046	Traction Devices for Use in the Home	-	-
E0890	Traction Frame Attach Pelvic	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.046	Traction Devices for Use in the Home	-	-
E0911	Hd Trapeze Bar Attach To Bed	predetermination to avoid post-service review.	DME101.001	Hospital Beds and Related Equipment	-	_
E0920	Fracture Frame Attached To B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.046	Traction Devices for Use in the Home	-	-
E0930	Fracture Frame Free Standing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	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 CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.023	Continuous Passive Motion (CPM) Device	-	-
E0942	Cervical Head Harness/Halter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.046	Traction Devices for Use in the Home	-	_
E0944	Pelvic Belt/Harness/Boot	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME101.046	Traction Devices for Use in the Home	_	_
E0946	Fracture Frame Dual W Cross	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.046	Traction Devices for Use in the Home		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
E0950	Tray	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E0953	W/C Lateral Thigh/Knee Sup	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E0954	Foot Box Any Type Each Foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E0955	Cushioned Headrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E0969	Wheelchair Narrowing Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E0981	Seat Upholstery Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E0982	Back Upholstery Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E0983	Add Pwr Joystick	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E0984	Add Pwr Tiller	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E0985		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
	W/C Seat Lift Mechanism	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E0986	Man W/C Push-Rim Powr System  Manual Wheelchair Accessory	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E0988	Lever-Activated Wheel Drive Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E0990	Wheelchair Elevating Leg Res	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E0992	Wheelchair Solid Seat Insert	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1002	Pwr Seat Tilt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1003	Pwr Seat Recline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1004	Pwr Seat Recline Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories		
E1005	Pwr Seat Recline Pwr	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E1006	Pwr Seat Combo W/O Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1007	Pwr Seat Combo W/Shear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1008	Pwr Seat Combo Pwr Shear	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories		
E1009	Add Mech Leg Elevation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1010	Add Pwr Leg Elevation	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1012	Ctr Mount Pwr Elev Leg Rest	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
	-	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	_
E1028	W/C Manual Swingaway	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_

E1036	Patient Transfer System >299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.034 DME101.010	Lifts and Elevator Systems Wheelchairs and Accessories	-	-
E1084	Hemi-Wheelchair Detachable A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E1085	Hemi-Wheelchair Fixed Arms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1100	Whchr S-Recl Fxd Arm Leg Res	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E1110	Wheelchair Semi-Recl Detach	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E1170	Whichr Ampu Fxd Arm Leg Rest	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E1171	Wheelchair Amputee W/O Leg R	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			-	_
E1172	Wheelchair Amputee Detach Ar	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E1180	Wheelchair Amputee W/ Foot R	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E1190	Wheelchair Amputee W/ Leg Re	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E1195	Wheelchair Amputee Heavy Dut	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E1223	Wheelchair Spec Size W Foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1225	Manual Semi-Reclining Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E1226	Manual Fully Reclining Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1227	Wheelchair Spec Sz Spec Ht A	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1228	Wheelchair Spec Sz Spec Ht B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E1229	Pediatric Wheelchair Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
E1230	Power Operated Vehicle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E1231	Rigid Ped W/C Tilt-In-Space	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		_
E1239	Ped Power Wheelchair Nos	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	DME101.010	Wheelchairs and Accessories	-	_
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
E1250	Wheelchair Lightwt Fixed Arm	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	DME101.010	Wheelchairs and Accessories	-	_
E1399	Durable Medical Equipment Mi	contract/clinical review.	-	-	-	-
E1699	Dialysis Equipment Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
E1700	Jaw Motion Rehab System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME103.009 SUR705.010	Mechanical Stretching Devices Temporomandibular Joint (TMJ) Disorders (TMJD)	_	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	DME103.009	Mechanical Stretching Devices		
E1701	Repl Cushions For Jaw Motion	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.010	Temporomandibular Joint (TMJ) Disorders (TMJD)	-	-
E1702	Repl Measr Scales Jaw Motion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME103.009	Mechanical Stretching Devices		
		(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR705.010 DME103.009	Temporomandibular Joint (TMJ) Disorders (TMJD)  Mechanical Stretching Devices		
E1821	Replacement Interface Spsd	predetermination to avoid post-service review.	DME103.001	Orthotics	-	_
E2201	Man W/Ch Acc Seat W>=20<23	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2202	Seat Width 24-27 In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2203	Frame Depth Less Than 22 In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2204	Frame Depth 22 To 25 In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2206	Man Wc Whl Lock Comp Repl Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2207	Crutch And Cane Holder	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
E2209	Arm Trough Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	
E2211	Pneumatic Propulsion Tire	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2212	Pneumatic Prop Tire Tube	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2213	Pneumatic Prop Tire Insert	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
	Pneumatic Caster Tire Each	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E2214		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2215	Pneumatic Caster Tire Tube	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2216	Foam Filled Propulsion Tire	mericine a. Procedure/service reviewed against Medical Policy Criteria. Submit for  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2217	Foam Filled Caster Tire Each	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2218	Foam Propulsion Tire Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2219	Foam Caster Tire Any Size Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2220	Solid Propuls Tire Repl Ea	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2221	Solid Caster Tire Repl Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2222	Solid Caster Integ Whl Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2228	Mwc Acc Wheelchair Brake	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		_
E2291	Planar Back For Ped Size Wc	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			_	
E2292	Planar Seat For Ped Size Wc	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2293	Contour Back For Ped Size Wc	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2294	Contour Seat For Ped Size Wc	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2300	Pwr Seat Elevation Sys	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E2301	Pwr Standing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
E2310	Electro Connect Btw Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E2311	Electro Connect Btw 2 Sys	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2312	Mini-Prop Remote Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
		p. addition to avoid post Sci vice review.				

E2313	Pwc Harness Expand Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E2321	Hand Interface Joystick	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2322	Mult Mech Switches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2323	Special Joystick Handle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2324	Chin Cup Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2325	Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
E2326	Breath Tube Kit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2327	Head Control Interface Mech	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2328	Head/Extremity Control Inter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2329	Head Control Nonproportional	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2330	Head Control Proximity Switc	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2331	Attendant Control	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2340	W/C Wdth 20-23 In Seat Frame	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2341	W/C Wdth 24-27 In Seat Frame	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	
E2342	W/C Dpth 20-21 In Seat Frame	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2343	W/C Dpth 22-25 In Seat Frame	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2351	Electronic Sgd Interface	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2358	Power Wheelchair Accessory Group 34 Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2359	Power Wheelchair Accessory Group 34 Sealed Lead Acid Battery Each (E.G. Gel Cell Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2360	22Nf Nonsealed Leadacid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2361	22Nf Sealed Leadacid Battery	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
E2362	Gr24 Nonsealed Leadacid	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2363	Gr24 Sealed Leadacid Battery	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2364	U1Nonsealed Leadacid Battery	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2365	U1 Sealed Leadacid Battery	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			-	_
E2366	Battery Charger Single Mode	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2367	Battery Charger Dual Mode	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2371	Gr27 Sealed Leadacid Battery	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2372	Gr27 Non-Sealed Leadacid	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2373	Hand/Chin Ctrl Spec Joystick	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
E2374	Hand/Chin Ctrl Std Joystick	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2375	Non-Expandable Controller	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2376	Expandable Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2377	Expandable Controller Initl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2397	Pwc Acc Lith-Based Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2500	Sgd Digitized Pre-Rec <=8Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2502	Sgd Prerec Msg >8Min <=20Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2504	Sgd Prerec Msg>20Min <=40Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	-
E2506	Sgd Prerec Msg > 40 Min	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2508	Sgd Spelling Phys Contact	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	_	_
E2510	Sgd W Multi Methods Msg/Accs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME104.009	Speech Generating Devices (SGD)	-	_
E2511	Sgd Sftwre Prgrm For Pc/Pda	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	_
E2512	Sgd Accessory Mounting Sys	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.009	Speech Generating Devices (SGD)	_	_
E2599	Sgd Accessory Noc	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	DME104.009	Speech Generating Devices (SGD)		_
E2601	Gen W/C Cushion Wdth < 22 In	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2602	Gen W/C Cushion Wdth >=22 In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2603	Skin Protect Wc Cus Wd <22In	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			-	
E2604	Skin Protect Wc Cus Wd>=22In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
E2605	Position Wc Cush Wdth <22 In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2606	Position Wc Cush Wdth>=22 In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	-
E2607	Skin Pro/Pos Wc Cus Wd <22In	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2608	Skin Pro/Pos Wc Cus Wd>=22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/sprice reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
E2609	Custom Fabricate W/C Cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2611	Gen Use Back Cush Wdth <22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2612	Gen Use Back Cush Wdth>=22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_

E2613	Position Back Cush Wd <22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2614	Position Back Cush Wd>=22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2615	Pos Back Post/Lat Wdth <22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2616	Pos Back Post/Lat Wdth>=22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
E2617	Custom Fab W/C Back Cushion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2620	Wc Planar Back Cush Wd <22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2621	Wc Planar Back Cush Wd>=22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
E2622	Adj Skin Pro W/C Cus Wd<22In	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
E2623	Adj Skin Pro Wc Cus Wd>=22In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2624	Adj Skin Pro/Pos Cus<22In	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
E2625	Adj Skin Pro/Pos Wc Cus>=21	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
	Wheelchair Accessory Shoulder	predetermination to avoid post-service review.	DIVILION OF	The Colon Suite Accessories	_	
E2626	Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2627	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable Rancho Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2628	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Reclining	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2629	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2630	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Monosuspension Arm And Hand Support Overhead Elbow Forearm Hand Sling Support Yoke Type Suspension Support	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2631	Wheelchair Accessory Addition To Mobile Arm Support Elevating Proximal Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
E2632	Or Lateral Rocker Arm With Elastic Balance Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
E2633	Wheelchair Accessory Addition To Mobile Arm Support Supinator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
G0176	Opps/Php;Activity Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014	Autism Spectrum Disorders (ASD)	-	-
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. May require Prior Authorization per contract agreement.	AIM Guidelines	-	-	-
G0255	Current Percep Threshold Tst	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.033 MED205.030	Automated Point-of-Care Nerve Conduction Testing Quantitative Sensory Testing	-	-
G0276	Pild/Placebo Control Clin Tr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
G0277	Hbot Full Body Chamber 30M	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	THE801.003	Hyperbaric Oxygen (HBO2) Therapy	_	_
G0281	Elec Stim Unattend For Press	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	-
G0282	Elect Stim Wound Care Not Pd	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027	Electrostimulation and Electromagnetic Therapy for Treating Wounds	-	-
G0293	Non-Cov Surg Proc Clin Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G0294	Non-Cov Proc Clinical Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G0295	Electromagnetic Therapy Onc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, 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	-	-
G0303	Pre-Op Service Lvrs 10-15Dos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.025	Pulmonary Rehabilitation	-	-
G0329	Electromagntic Tx For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.027 THE803.008	Electrostimulation and Electromagnetic Therapy for Treating Wounds Non Covered Physical Therapy Services	-	-
G0341	Percutaneous Islet Celltrans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	-	-
G0342	Laparoscopy Islet Cell Trans	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	-	-
G0343	Laparotomy Islet Cell Transp	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.013	Pancreas and Related Organ Tissue Transplantation	-	-
G0406	Inpt/Tele Follow Up 15	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0407	Inpt/Tele Follow Up 25	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0408	Inpt/Tele Follow Up 35	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0416	Prostate Biopsy Any Mthd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR717.015	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with Biopsy	-	-
G0422	Intens Cardiac Rehab W/Exerc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	-	-
G0423	Intens Cardiac Rehab No Exer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	THE803.023	Cardiac Rehabilitation (CR)	_	_
G0425	Inpt/Ed Teleconsult30	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0426	Inpt/Ed Teleconsult50	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	12/31/2020
		reven.				

		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G0427	Inpt/Ed Teleconsult70  Collagen Meniscus Implant	review.	-	-	-	12/31/2020
G0428	Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). May require Prior Authorization per contract agreement	SUR705.034	Meniscal Allografts and Other Meniscal Implants	-	-
G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	_
	Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
G0455	Fecal Microbiota Prep Instil	predetermination to avoid post-service review.	SUR703.049	Fecal Microbiota Transplantation (FMT)	_	_
G0459	Telehealth Inpt Pharm Mgmt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0460	Autologous Prp For Ulcers	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non- Orthopedic Conditions	-	-
G0508	Crit Care Telehea Consult 60	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0509	Crit Care Telehea Consult 50	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	12/31/2020
G0511	Ccm/Bhi By Rhc/Fqhc 20Min Mo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G0518	Remove W Insert Drug Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.007 RX501.076 RX501.082	Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies Treatment of Opioid Dependence	-	-
G2011	Alcohol/Sub Misuse Assess	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G2058	Ccm Add 20Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	12/31/2020
G2064	Md Mang High Risk Dx 29	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G2065	Clin Mang H Risk Dx 29	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		
G2082	Visit Esketamine 56M Or Less	review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray	-	4/15/2021
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	7/13/2021
G2082	Visit esketamine 56m or less	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray	08/01/2021	
G2083	Visit Esketamine > 56M	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray	-	4/15/2021
G2083	Visit esketamine > 56m	predetermination to avoid post-service review.	RX501.106	Esketamine Nasal Spray	08/01/2021	-
G8395	Lvef>=40% Doc Normal Or Mild	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8396	Lvef Not Performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8397	Dil Macula/Fundus Exam/W Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	-
G8398	Dil Macular/Fundus Not Perfo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	12/31/2020
G8399	Pt W/Dxa Results Document	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G8400	Pt W/Dxa No Results Doc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_		_
G8404	Low Externity Neur Exam Docum	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_ <del></del>		
G8405	Low Externity Neur Not Perfor	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		
G8410	Eval On Foot Documented	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G8415	Eval On Foot Not Performed	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
G8416	Pt Inelig Footwear Evaluatio	review.	-	-	-	-
G8417	Calc Bmi Abv Up Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8418	Calc Bmi Blw Low Param F/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8419	Calc Bmi Out Nrm Param Nof/U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8420	Calc Bmi Norm Parameters	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8421	Bmi Not Calculated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	-
G8422	Pt Inelig Bmi Calculation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G8427	Docrev Cur Meds By Elig Clin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
G8428	Cur Meds Not Document	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
G8430	Ec At Doc Medrec Pt Not Elig	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_		_
G8431	Pos Clin Depres Scrn F/U Doc	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-	
G8432	Dep Scr Not Doc Rng	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-	
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G8433	Scr For Dep Not Cpt Doc Rsn	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	=	-
G8442	Doc Pain As Nt Perf Not Elg	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-		-	12/31/2020
G8450	Beta-Bloc Rx Pt W/Abn Lvef	review.	-	-	-	-
G8451	Pt W/Abn Lvef Inelig B-Bloc	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8452	Pt W/Abn Lvef B-Bloc No Rx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8465	High Risk Recurrence Pro Ca	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8473	Ace/Arb Thxpy Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8474	Ace/Arb Not Rx'D; Doc Reas	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
G8475	Ace/Arb Thxpy Not Rx?D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
G8476	Bp Sys <140 And Dias <89	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G8477		and device	-	-	-	-
G8477	Bp Sys>=140 And/Or Dias >=89  Bp Not Performed/Doc	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G8477 G8478 G8482	Bp Sys>=140 And/Or Dias >=89  Bp Not Performed/Doc  Flu Immunize Order/Admin		-	-		-

G8483	Flu Imm No Admin Doc Rea	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G8484	Flu Immunize No Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G9012	Other Specified Case Mgmt	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
G9050	Oncology Work-Up Evaluation	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9051		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_ <del>-</del>		_
	Oncology Tx Decision-Mgmt	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
G9052	Onc Surveillance For Disease	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9053	Onc Expectant Management Pt	review.	-	-	-	-
G9054	Onc Supervision Palliative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
G9055	Onc Visit Unspecified Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9056	Onc Prac Mgmt Adheres Guide	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9057	Onc Pract Mgmt Differs Trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G9058	Onc Prac Mgmt Disagree W/Gui	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
G9059	Onc Prac Mgmt Pt Opt Alterna	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9060	Onc Prac Mgmt Dif Pt Comorb	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_ <del>-</del>		_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_ <del>-</del>		-
G9061	Onc Prac Cond Noadd By Guide	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_ <del>-</del>	_	-
G9062	Onc Prac Guide Differs Nos	review.	-	-	-	-
G9063	Onc Dx Nsclc Stgi No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9064	Onc Dx Nsclc Stg2 No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9065	Onc Dx Nsclc Stg3A No Progre	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
G9066	Onc Dx Nsclc Stg3B-4 Metasta	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9067	Onc Dx Nsclc Dx Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
G9068	Onc Dx Sclc/Nsclc Limited	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9069	Onc Dx Scic/Nscic Ext At Dx	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_ <del>-</del>	-	_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	_ <del>-</del>	-	-
G9070	Onc Dx Scic/Nscic Ext Unknwn	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	<del>-</del>	-	-
G9071	Onc Dx Brst Stg1-2B Hr Nopro	review.	-	-	-	-
G9072	Onc Dx Brst Stg1-2 Noprogres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9073	Onc Dx Brst Stg3-Hr No Pro	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
G9074	Onc Dx Brst Stg3-Noprogress	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9075	Onc Dx Brst Metastic/ Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
G9077	Onc Dx Prostate T1No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9078	Onc Dx Prostate T2No Progres	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G9079	Onc Dx Prostate T3B-T4Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9080	Onc Dx Prostate W/Rise Psa	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-	-
G9083	Onc Dx Prostate Unknwn Nos	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9084	Onc Dx Colon T1-3 N1-2 No Pr	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	-
G9085	Onc Dx Colon T4 N0 W/O Prog	review.	-	-	-	-
G9086	Onc Dx Colon T1-4 No Dx Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9087	Onc Dx Colon Metas Evid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9088	Onc Dx Colon Metas Noevid Dx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9089	Onc Dx Colon Extent Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G9090	Onc Dx Rectal T1-2 No Progr	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
G9091	Onc Dx Rectal T3 N0 No Prog	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		_		_
G9092	Onc Dx Rectal T1-3 N1-2Noprg	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9093	Onc Dx Rectal T4 N M0 No Prg	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
G9094	Onc Dx Rectal M1 W/Mets Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9095	Onc Dx Rectal Extent Unknwn	review.	-	-	-	-
G9096	Onc Dx Esophag T1-T3 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9097	Onc Dx Esophageal T4 No Prog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9098	Onc Dx Esophageal Mets Recur	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G9099	Onc Dx Esophageal Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9100	Onc Dx Gastric No Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
G9101	Onc Dx Gastric P R1-R2Noprog	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9102	Onc Dx Gastric Unresectable	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	<del>-</del>	-	-
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
G9103	Onc Dx Gastric Recurrent	review.	-	-	-	-
		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9104	Onc Dx Gastric Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9104 G9105	Onc Dx Gastric Unknown Nos Onc Dx Pancreatc P RO Res No	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	- - -	- -	- -
G9105	Onc Dx Pancreatc P RO Res No	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	- - -	- - - -	- - -	- - -

G9108	Onc Dx Pancreatic Unknwn Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9109	Onc Dx Head/Neck T1-T2No Prg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
G9110	Onc Dx Head/Neck T3-4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G9111	Onc Dx Head/Neck M1 Mets Rec	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9112	Onc Dx Head/Neck Ext Unknown	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	<u>-</u>		-
G9113	Onc Dx Ovarian Stg1A-B No Pr	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	-
G9114	Onc Dx Ovarian Stg1A-B Or 1	review.	-	-	-	-
G9115	Onc Dx Ovarian Stg3/4 Noprog	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
G9116	Onc Dx Ovarian Recurrence	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9117	Onc Dx Ovarian Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G9123	Onc Dx Cml Chronic Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
G9124	Onc Dx Cml Acceler Phase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
G9125	Onc Dx Cml Blast Phase	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9126	Onc Dx Cml Remission	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	<u>-</u>		-
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	<u>-</u>	_	_
G9128	Onc Dx Multi Myeloma Stage I	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
G9129	Onc Dx Mult Myeloma Stg2 Hig	review.	-	-	-	-
G9130	Onc Dx Multi Myeloma Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9131	Onc Dx Brst Unknown Nos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	_
G9132	Onc Dx Prostate Mets No Cast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
G9133	Onc Dx Prostate Clinical Met	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
G9134	Onc Nhistg 1-2 No Relap No	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
G9135	Onc Dx Nhl Stg 3-4 Not Relap	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9136	Onc Dx Nhl Trans To Lg Bcell	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
G9137	Onc Dx Nhl Relapse/Refractor	review.	-	-	-	-
G9138	Onc Dx Nhl Stg Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
G9139	Onc Dx Cml Dx Status Unknown	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
G9140	Frontier Extended Stay Demo	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
	Treatment (Oivit) Either Pulsatile Or Continuous By Any Means Guided By The Results Of	FILL Decodes (continued to the Discount of the				
G9147		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
G9147	Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose;	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
G9147	Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose;	Check EU policy CPCP028, 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.	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
	Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration	Check EIU policy CPCP028, 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	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
G9481	Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration	Check EIU policy CPCP028, 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 not covered by the Plan. Not subject to pre-service	MED201.028	Intermittent Intravenous Insulin Therapy	- -	-
G9481 G9482	Measurements For:Respiratory Quotient, And/or Ivine Urea Nitrogen (Uni); And/or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration Remote E/M New Pt 10Mins Remote E/M New Pt 20Mins	Check EU policy CPCP028, 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.	MED201.028	Intermittent Intravenous Insulin Therapy	- - -	-
G9481 G9482 G9483	Measurements For-Respiratory Quotient, And/Or Urine Urea Nitrogen (Juni); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins	Check EU policy CPCP028, 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.	ME0201.028	Intermittent Intravenous Insulin Therapy	-	
G9481 G9482 G9483 G9484	Measurements For-Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration Remote E/M New Pt 10Mins Remote E/M New Pt 20Mins Remote E/M New Pt 30Mins Remote E/M New Pt 45Mins	Check EU policy CPCP028, 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.	MED201.028	Intermittent Intravenous Insulin Therapy	-	-
G9481 G9482 G9483 G9484 G9486	Measurements For-Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M New Pt 60Mins  Remote E/M Set Pt 10Mins	Check EIU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	— — — — — — — — — — — — — — — — — — —	Intermittent Intravenous Insulin Therapy	-	-
G9481 G9482 G9483 G9484 G9485 G9487	Measurements For-Respiratory Quotient; And/Or Urine Urea Nitrogen (Juni); And/Or Arterial Venous Or Capillary Glucoes; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 10Mins	Check EIU policy CPCP028, 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.	— — — — — — — — — — — — — — — — — — —	Intermittent Intravenous Insulin Therapy	-	-
G9481 G9482 G9483 G9484 G9485 G9486 G9487	Measurements For-Respiratory Quotient, And/or Urine Urea Nitrogen (Juni); And/or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 15Mins	Check EU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	— — — — — — — — — — — — — — — — — — —	Intermittent Intravenous Insulin Therapy	-	-
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488	Measurements For-Respiratory Quotient, And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 25Mins  Remote E/M Est. Pt 25Mins	Check EU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	— — — — — — — — — — — — — — — — — — —	Intermittent Intravenous Insulin Therapy		-
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488	Measurements For-Respiratory Quotient, And/or Urine Urea Nitrogen (Juni); And/or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 15Mins	Check EU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unitsted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	— — — — — — — — — — — — — — — — — — —	Intermittent Intravenous Insulin Therapy		
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488	Measurements For-Respiratory Quotient, And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 25Mins  Remote E/M Est. Pt 25Mins	Check EU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	- - - - - - -		-	-
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488 G9489	Measurements For-Respiratory Quotient; And/Or Urine Urea Untrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M New Pt 60Mins  Remote E/M Est. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 25Mins  Remote E/M Est. Pt 40Mins  Remote E/M Est. Pt 40Mins	Check EIU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Not Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.				
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488 G9489 H0046 H0047	Measurements For-Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M Set Pt 10Mins  Remote E/M Est. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 25Mins  Remote E/M Est. Pt 40Mins  Mental Health Service Nos  Alcohol/Drug Abuse Svc Nos	Check EIU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	- - - - - - - - - - - - - - - - - - -			
G9481 G9482 G9483 G9484 G9485 G9486 G9487 G9488 G9489 H0046 H0047	Measurements For-Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration  Remote E/M New Pt 10Mins  Remote E/M New Pt 20Mins  Remote E/M New Pt 30Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 45Mins  Remote E/M New Pt 60Mins  Remote E/M St. Pt 10Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 15Mins  Remote E/M Est. Pt 25Mins  Remote E/M Est. Pt 40Mins  Remote E/M Est. Pt 40Mins  Mental Health Service Nos  Alcohol/Drug Abuse Svc Nos  Abatacept Injection	Check EU policy CPCP028, 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.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.			-	-
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J0585	Injection Onabotulinumtoxina	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	_	_
J0586	Abobotulinumtoxina	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.019 MED201.014	Botulinum Toxin	_	_
J0587	Inj Rimabotulinumtoxinb	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.019	Treatment of Hyperhidrosis  Botulinum Toxin		_
		Prior Authorization per contract agreement.	MED201.014	Treatment of Hyperhidrosis		-
J0588		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	-	-
J0591	Inj Deoxycholic Acid 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
	,,	review.			-	-
J0598	C-1 Esterase Cinryze	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.013 RX501.096	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide Specialty Medication Administration Site of Care	-	-
J0638	Canakinumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.119	Canakinumab		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096 RX501.111	Specialty Medication Administration Site of Care Certolizumab Pegol		-
J0717	Certolizumab Pegol Inj 1Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096	Specialty Medication Administration Site of Care	-	-
J0775	Collagenase Clost Hist Inj	Prior Authorization per contract agreement.	RX501.073	Clostridial Collagenase for Fibroproliferative Disorders	-	-
J0791	Inj Crizanlizumab-Tmca 5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.126 RX501.096	Crizanlizumab-tmca Specialty Medication Administration Site of Care	3/1/2021	_
J0881	Darbepoetin Alfa Non-Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
J0885	Epoetin Alfa Non-Esrd	Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	-
J0888	Epoetin Beta Non Esrd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	_
J0896	Inj luspatercept-aamt 0.25mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	08/01/2021	10/10/2021
J1290	Ecallantide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX504.013	Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide		
31290	Ecaliantide Injection	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	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.095 RX501.096	Edaravone	_	_
J1303	Inj. Ravulizumab-Cwvz 10 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.107	Specialty Medication Administration Site of Care Ravulizumab-cwvz (Ultomiris)		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096	Specialty Medication Administration Site of Care	40/4/2000	-
J1305	Inj Evinacumab-Dgnb 5Mg	predetermination to avoid post-service review.	RX501.136 RX501.067	Evinacumab-dgnb	10/1/2021	-
J1322	Elosulfase Alfa Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
J1325	Epoprostenol Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	_
J1426	Injection Casimersen 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.135	Casimersen	10/1/2021	_
J1427	Vitolarsen, 10 mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.129	Vitolarsen	5/1/2021	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require				
J1428	Inj Eteplirsen 10 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.084	Eteplirsen	-	-
J1429	Inj Golodirsen 10 Mg	predetermination to avoid post-service review.	RX501.122	Golodirsen	-	-
J1458	Galsulfase Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	-
J1459	Inj Ivig Privigen 500 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Specialty Medication Administration Site of Care	_	_
J1554	Injection, immune globulin	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	_
	(asceniv), 500mg	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	RX504.003 RX504.003	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])  Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])	4/1/2021	-
J1555	(asceniv), 500mg Inj Cuvitru 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX504.003 RX501.096	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])  Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])  Specialty Medication Administration Site of Care	4/1/2021	-
	(asceniv), 500mg	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	RX504.003 RX504.003	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])  Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])	4/1/2021 - -	-
J1555 J1556	(asceniv), 500mg Inj Cuvitru 100 Mg Inj Imm Glob Bivigam 500Mg Injection Immune Globulin	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX504.003 RX504.003 RX501.096 RX504.003 RX501.096	Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG])	4/1/2021 - -	-
J1555	(asceniv), 500mg Inj Cuvitru 100 Mg Inj Imm Glob Bivigam 500Mg	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, may require Prior Authorization per contract agreement.	RX504.003 RX504.003 RX501.096 RX504.003 RX501.096	Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Specially Medication Administration Site of Care Immunoglobulin (ig) Therapy (including intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care	4/1/2021	- - -
J1555 J1556	(asceniv), 500mg  Inj Cuvitru 100 Mg  Inj Imm Glob Bivigam 500Mg  Injection Immune Globulin (Gammaplex) Intravenous Non-	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX504.003 RX501.096 RX504.003 RX501.096 RX504.003 RX501.096	Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (Including Intravenous [IVIG] and Subcutaneous ig [SCIG])	4/1/2021	-
J1555 J1556 J1557	(asceniv), 500mg Inj Cuvitru 100 Mg Inj Imm Glob Bivigam 500Mg Injection Immune Globulin (Gammajlex) Intravenous Non- tyophilized (E.G. Liquid) 500 Mg Inj. Xembify 100 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX504.003 RX501.006 RX501.096 RX501.096 RX504.003 RX501.096 RX504.003 RX501.006 RX504.003 RX501.006 RX504.003	Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care  Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care  Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care  Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG]) Specialty Medication Administration Site of Care  Immunoglobulin (ig) Therapy (including Intravenous [IVIG] and Subcutaneous ig [SCIG])	4/1/2021 - - -	-
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J1951	Inj fensolvi 0.25 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	7/1/2021	_
J2182	Injection Mepolizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.080 RX501.096	Mepolizumab Specialty Medication Administration Site of Care	_	_
J2278	Ziconotide Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.060	Ziconotide		
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J2323	Natalizumab Injection	Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2326	Inj Nusinersen 0.1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.086	Nusinersen	_	_
J2350	Injection Ocrelizumab 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.085	Ocrelizumab		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096 RX501.058	Specialty Medication Administration Site of Care Omalizumab	-	-
J2357	Omalizumab Injection	Prior Authorization per contract agreement.	RX501.096	Specialty Medication Administration Site of Care	-	-
J2502	Inj Pasireotide Long Acting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.079	Pasireotide	-	-
J2503	Pegaptanib Sodium Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.027 OTH903.020	Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions		
		predetermination to avoid post-service review.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)		
J2507	Injection Pegloticase 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.120 RX501.096	Pegloticase Specialty Medication Administration Site of Care	-	-
J2562	Plerixafor Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	_	_
J2786	Injection Reslizumab 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.083	Reslizumab		_
J2840		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096 RX501.067	Specialty Medication Administration Site of Care Enzyme-Replacement Therapy for Lysosomal Storage Disorders		_
	Inj Sebelipase Alfa 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096	Specialty Medication Administration Site of Care	-	-
J2860	Injection Siltuximab	Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J3032	Inj. Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.124 RX501.096	Eptinezumab-jjmr Specialty Medication Administration Site of Care	_	_
J3060	Inj Taliglucerace Alfa 10 U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_
J3121	Inj Testostero Enanthate 1Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.076 SUR717.001	Testosterone Replacement Therapies Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	-	
J3145	Testosterone Undecanoate 1Mg	Prior Authorization per contract agreement.	RX501.076	Testosterone Replacement Therapies	-	-
J3241	Inj. Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.110	Specialty Medication Administration Site of Care Teprotumumab	-	_
J3245	Inj. Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.096 RX501.123	Specialty Medication Administration Site of Care Tildrakizumab-asmn	_	_
J3262	Tocilizumab Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096	Specialty Medication Administration Site of Care		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.115	Tocilizumab	<del>-</del>	
J3285	Treprostinil Injection	Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	-
J3301	Triamcinolone Acet Inj Nos	contract/clinical review.	-	-	-	05/04/2021
J3315	Triptorelin Pamoate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	_	_
J3316	Inj. Triptorelin Xr 3.75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.041 RX501.040	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	_	_
J3358	Ustekinumab Iv Inject 1 Mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096	Human Growth Hormone (GH)  Specialty Medication Administration Site of Care		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.114 RX501.096	Ustekinumab Specialty Medication Administration Site of Care	-	
J3380	Injection Vedolizumab	Prior Authorization per contract agreement.	RX501.117	Vedolizumab	-	-
J3385	Velaglucerase Alfa	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.067 RX501.096	Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	_	_
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J3396	Verteporfin Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	-	_
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J3396 J3397	Verteporfin Injection  Inj. Vestronidase Alfa-Vjbk	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.	OTH903.015	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)	-	-
		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, may require	OTH903.015 RX501.067	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders	-	-
J3397	Inj. Vestronidase Alfa-Vjbk	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	OTH903.015 RX501.067 RX501.096	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care	-	- - -
J3397 J3398 J3399	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to Unitsted: Procedure/service not specifically defined or classified, maybe subject to	OTH903.015  RX501.067  RX501.096  RX501.098	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders  Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy	-	- - -
13397 13398 13399 13490	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	OTH903.015  RX501.067  RX501.096  RX501.098  RX501.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)	-	- - - -
J3397 J3398 J3399	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	OTH903.015  RX501.067  RX501.096  RX501.098	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders  Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy	-	-
13397 13398 13399 13490	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Not Covered: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	OTH903.015  RX501.067  RX501.096  RX501.098  RX501.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)	-	-
J3397 J3398 J3399 J3490 J3520	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinial review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to Unlisted: Procedure/service not specifically defined or classified, maybe subject to Unlisted: Procedure/service not specifically defined or classified, maybe subject to	OTH903.015  RX501.067  RX501.096  RX501.098  RX501.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)	-	-
J3397 J3398 J3399 J3490 J3520	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service neviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	OTH903.015  RX501.067  RX501.096  RX501.098  RX501.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)		- - - - -
13397 13398 13399 13490 13520 13570 13590	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104  - THE801.008  -	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec.xiol)  - Chelation Therapy  -		- - - - - -
J3397 J3398 J3399 J3490 J3520 J3570 J3590 J3591 J7177	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Nno Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)  Chelation Therapy  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)	-	- - - - - -
13397 13398 13399 13490 13520 13570 13590	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Nan Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Vulnisted: Procedure/service not covered by the Plan. Not subject to contract/Clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination per contract agreement.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104  - THE801.008  -	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec.xiol)  - Chelation Therapy  -		- - - - - - -
J3397 J3398 J3399 J3490 J3520 J3570 J3590 J3591 J7177	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)  Chelation Therapy  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)		- - - - - - - - -
J3397 J3398 J3399 J3490 J3520 J3570 J3590 J3591 J7177 J7178	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. May require Prior Authorization per contract agreement.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract defined per contract agreement.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)  Chelation Therapy  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)		- - - - - - - -
J3397 J3398 J3399 J3490 J3520 J3570 J3590 J3591 J7177 J7178 J7192	Inj. Vestronidase Alfa-Vjbk Inj Luxturna 1 Billion Vec G Inj Onase Abepar-Xioi Treat Drugs Unclassified Injection Edetate Disodium Per 150 Mg Laetrile Amygdalin Vit B16 Unclassified Biologics Esrd On Dialysi Drug/Bio Noc Inj. Fibryga 1 Mg Inj Human Fibrinogen Con Nos Factor Viii Recombinant Nos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  NP Criteria: Procedure/service not covered by the Plan. Not subject to pre-service review.  Not Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  NP Criteria: Procedure/service not covered by the Plan. Not subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.	OTH903.015  RXS01.067  RXS01.096  RXS01.098  RXS01.104	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec-xioi)  Chelation Therapy  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)		- - - - - - - - -
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J3397  J3398  J3399  J3490  J3520  J3570  J3590  J3591  J7177  J7178  J7192  J7195  J7309  J7316  J7340  J7607  J7609  J7610  J7615	Inj. Vestronidase Alfa-Vjbk  Inj Luxturna 1 Billion Vec G  Inj Onase Abepar-Xioi Treat  Drugs Unclassified Injection  Edetate Disodium Per 150 Mg  Laetrile Amygdalin Vit B16  Unclassified Biologies  Esrd On Dialysi Drug/Bio Noc  Inj. Fibryga 1 Mg  Inj Human Fibrinogen Con Nos  Factor Viii Recombinant Nos  Factor Viii Recombinant Nos  Hemophilia Clot Factor Noc  Methyl Aminolevulinate Top  Inj Ocriplasmin 0.125 Mg  Carbidopa Levodopa Ent 100Ml  Immunosuppressive Drug Noc  Acetylcysteine Comp Unit  Levalbuterol Comp Con  Albuterol Comp Unit	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, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Non Covered: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Unitsted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  Unitsted: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specifically defined or classified, maybe subject to contract/Clinical review.  MP Criteria: Procedure/service not specif	OTH903.015  RXS01.067  RXS01.098  RXS01.098  RXS01.104  - THE801.008  RXS01.072  RXS01.072  THE801.027  OTH903.026  RXS04.015  - RXS01.063  RXS01.063  RXS01.063	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care  Gene Therapy for Inherited Retinal Dystrophy  Zolgensma (onasemnogene abeparvovec.xiol)  - Chelation Therapy  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)  Human Fibrinogen Concentrate (RiaSTAP and Fibryga)  Corpounded Applications of Photodynamic Therapy (PDT)  Ocriplasmin for Symptomatic Vitreomacular Adhesion  Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease.  - Compounded Drug Products		

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
J7627	Budesonide Comp Unit	Check EIU policy CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	RX501.063	Compounded Drug Products	-	-
J7699	Inhalation Solution For Dme	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
J7799	Non-Inhalation Drug For Dme	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
17999	Compounded Drug Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
J8498	Antiemetic Rectal/Supp Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	-
18499	Oral Prescrip Drug Non Chemo	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
J8597	Antiemetic Drug Oral Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
18999	Oral Prescription Drug Chemo	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
J9020	Asparaginase Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	_
J9022	Inj Atezolizumab 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	_	10/10/2021
J9023	Injection Avelumab 10 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		10/10/2021
J9032	Injection Belinostat 10Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		
19035	Bevacizumab Injection	Prior Authorization per contract agreement.  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	_	_
J9037	Injection, belantamab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	OTH903.015 RX502.061	Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)  Oncology Medications	4/1/2021	10/10/2021
	mafodontin-blmg, 0.5mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Oncology Medications	4/1/2021	
J9039	Injection Blinatumomab	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	10/10/2021
J9043	Injection Cabazitaxel 1 Mg	Prior Authorization per contract agreement. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	RX502.061	Oncology Medications	-	10/10/2021
J9044	Inj Bortezomib Nos 0.1 Mg	contract/Clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	-	-	-	-
J9047	Injection Carfilzomib 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	10/10/2021
J9057	Inj. Copanlisib 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021

J9119	Inj. Cemiplimab-Rwlc 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	10/10/2021
J9144	Daratumumab Hyaluronidase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	2/1/2021	10/10/2021
J9145	Injection Daratumumab 10 Mg	MP Criteria: Procedure/service review.  MP Criteria: Procedure/service review against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9153	Inj Daunorubicin Cytarabine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	_	_
J9155	Degarelix Injection	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	_	_
J9173	Inj. Durvalumab 10 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		10/10/2021
J9176	Injection Elotuzumab 1Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		10/10/2021
J9177	Inj Enfort Vedo-Ejfv 0.25Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	-	10/10/2021
J9202	Goserelin Acetate Implant	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists		,,
J9203		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	10/10/2021
	Gemtuzumab Ozogamicin 0.1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	10/10/2021
J9204	Inj Mogamulizumab-Kpkc 1 Mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	
J9205	Inj Irinotecan Liposome 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	10/10/2021
J9217	Leuprolide Acetate Suspnsion	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists		-
J9219	Leuprolide Acetate Implant	Prior Authorization per contract agreement.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	-	-
J9223	Inj. Lurbinectedin 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	2/1/2021	10/10/2021
J9225	Vantas Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	-
J9226	Supprelin La Implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	-	-
J9227	Inj. Isatuximab-Irfc 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	10/10/2021
J9228	Injection Ipilimumab 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9229	Inj Inotuzumab Ozogam 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9264	Paclitaxel Protein Bound	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX502.061	Oncology Medications	-	10/10/2021
J9269	Inj. Tagraxofusp-Erzs 10 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	10/10/2021
J9271	Inj Pembrolizumab	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	_	10/10/2021
J9281	Mitomycin Instillation	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	2/1/2021	10/10/2021
J9285	Inj Olaratumab 10 Mg	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			5/15/2021	
J9285	Inj Olaratumab 10 Mg	review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		
J9295	Injection Necitumumab 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	_
J9299	Injection Nivolumab	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	<del>-</del>	10/10/2021
J9301	Obinutuzumab Inj	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061		<del>-</del>	10/10/2021
19306	Injection Pertuzumab 1 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	<del>-</del>	10/10/2021
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require		Oncology Medications	<del>-</del>	10/10/2021
19308	Injection Ramucirumab	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	-	
19309	Inj Polatuzumab Vedotin 1Mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	10/10/2021
J9311	Inj Rituximab Hyaluronidase	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications	-	-
J9312	Inj. Rituximab 10 Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	-	-
J9313	Inj. Lumoxiti 0.01 Mg	predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	10/10/2021
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase- zzxf, per 10 mg	$\label{lem:mapping} \mbox{MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.}$	RX502.061	Oncology Medications	5/1/2021	10/10/2021
J9317	Injection, sacituzumab govitecan- hziv. 2.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	2/1/2021	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	_	_
J9349	Injection, tafasitamab-cxix, 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	4/1/2021	10/10/2021
J9352	Injection Trabectedin 0.1Mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Price Authorization per contract agreement.	RX502.061	Oncology Medications	_	10/10/2021
J9354	Inj Ado-Trastuzumab Emt 1Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX502.061	Oncology Medications		10/10/2021
J9358	Inj Fam-Trastu Deru-Nxki 1Mg	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.061	Oncology Medications	2/1/2021	10/10/2021
J9600	Porfimer Sodium Injection	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.029	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus		
19999	Chemotherapy Drug	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to			-	_
K0010	Stnd Wt Frame Power Whichr	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	- Wheelchairs and Accessories	-	-
	Stnd Wt Frame Power Whichr Stnd Wt Pwr Whichr W Control	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010		-	-
K0011		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories	_	-
K0012	Ltwt Portbl Power Whichr	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	_
K0013	Custom Power Whichr Base	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	-	-
K0056	Seat Ht <17 Or >=21 Ltwt Wc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0108	W/C Component-Accessory Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	DME101.010	Wheelchairs and Accessories	_	-
K0455	Pump Uninterrupted Infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	_	-
K0669	Seat/Back Cus No Dmepdac Ver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
K0743	Suction Pump Home Model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.036	Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds	_	
	Portable For Use On Wounds	predetermination to avoid post-service review.			-	

K0744	Absorptive Wound Dressing For Use With Suction Pump Home Model Portable Pad Size 16 Square Inches Or Less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.036	Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds	-	-
K0745	Absorptive Wound Dressing For Use With Suction Pump Home Model Portable Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.036	Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds	-	-
к0746	Absorptive Wound Dressing For Use With Suction Pump Home	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.036	Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds	-	-
к0800	Pov Group 1 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0801	Pov Group 1 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
К0802	Pov Group 1 Vhd 451-600 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	
K0806	Pov Group 2 Std Up To 300Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	
K0807	Pov Group 2 Hd 301-450 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0808	Pov Group 2 Vhd 451-600 Lbs	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0812	Power Operated Vehicle Noc	predetermination to avoid post-service review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	DME101.010	Wheelchairs and Accessories	_	_
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0813	Pwc Gp 1 Std Port Seat/Back	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		-
K0814	Pwc Gp 1 Std Port Cap Chair	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0815	Pwc Gp 1 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	_	
K0816	Pwc Gp 1 Std Cap Chair	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories		
K0820	Pwc Gp 2 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	-	-
K0821	Pwc Gp 2 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	-	-
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	Pwc Gp Vhd Cap Chair	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0828	Pwc Gp 2 Xtra Hd Seat/Back	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
K0829	Pwc Gp 2 Xtra Hd Cap Chair	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0830	Pwc Gp2 Std Seat Elevate S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0831	Pwc Gp2 Std Seat Elevate Cap	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 Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0837	Pwc Gp 2 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
K0838	Pwc Gp 2 Hd Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
к0839	Pwc Gp2 Vhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0840	Pwc Gp2 Xhd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0841	Pwc Gp2 Std Mult Pow Opt S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	
K0842	Pwc Gp2 Std Mult Pow Opt Cap	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0843	Pwc Gp2 Hd Mult Pow Opt S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wheelchairs and Accessories		
K0848	Pwc Gp 3 Std Seat/Back	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010			
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.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	-
K0851	Pwc Gp 3 Hd Cap Chair	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	_	
к0853	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 predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	
K0855	Pwc Gp 3 Xhd Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	-
K0856	Pwc Gp3 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	-	_
K0857	Pwc Gp3 Std Sing Pow Opt Cap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0858	Pwc Gp3 Hd Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0859	Pwc Gp3 Hd Sing Pow Opt Cap	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0860	Pwc Gp3 Vhd Sing Pow Opt S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			-	-
K0861	Pwc Gp3 Std Mult Pow Opt S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0862	Pwc Gp3 Hd Mult Pow Opt S/B	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0863	Pwc Gp3 Vhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories		
K0864	Pwc Gp3 Xhd Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	
к0868	Pwc Gp 4 Std Seat/Back	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	

K0869	Pwc Gp 4 Std Cap Chair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	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.	DME101.010	Wheelchairs and Accessories	-	-
K0871	Pwc Gp 4 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	_	_
K0877	Pwc Gp4 Std Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0878	Pwc Gp4 Std Sing Pow Opt Cap	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories		
K0879	Pwc Gp4 Hd Sing Pow Opt S/B	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		Wholehoire and Assessaries	-	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	-	
K0880	Pwc Gp4 Vhd Sing Pow Opt S/B	predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	_
K0884	Pwc Gp4 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	-	_
K0885	Pwc Gp4 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	-	-
к0886	Pwc Gp4 Hd Mult Pow S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	-	-
к0890	Pwc Gp5 Ped Sing Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME101.010	Wheelchairs and Accessories	_	_
K0891	Pwc Gp5 Ped Mult Pow Opt S/B	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	Wheelchairs and Accessories	_	_
K0898	Power Wheelchair Noc	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
к0899	Pow Mobil Dev No Dmepdac	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.010	- Wheelchairs and Accessories		-
KU033	row woodi Dev No Dillepuac	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	DWE101.010	Milearnique qua vicessonies	_	_
K1002	Ces System W/Supplies Access	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
K1004	Lo Freq Us Diathermy Device	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.008	Non Covered Physical Therapy Services	-	-
K1007	Bil Hkaf Pc S/D Micro Sensor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	DME103.008	Powered Exoskeleton for Ambulation in Patients With Lower-Limb Disabilities	3/1/2021	
		(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				-
K1009	Speech Volume Modulation Sys	predetermination to avoid post-service review.	THE803.014	Speech-Language Therapy (SLT)	-	2/28/2021
K1009	Speech Volume Modulation Sys	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	THE803.014	Speech-Language Therapy (SLT)	3/1/2021	_
		(CPCP).  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			. / . /	
K1013	Enema Tube Any Replac Only	review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	4/1/2021	-
K1018	Ext Up Limb Tremor Stim Wris	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	CPCP028	Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU)	8/15/2021	-
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
K1019	Monthly Supp Use With K1018	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	CPCP028	Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU)	8/15/2021	-
K1020	Non-invasive vagus nerv stim	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR712.021	Vagus Nerve Stimulation (VNS)	7/1/2021	_
K1023	Trans Elec Nerv Periph Nerv	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	MED201.040	Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain	10/1/2021	_
K1024	Non Pneum Comp Control Cal	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Reprocessing (TEMPR)  Experimental, Investigational and/or Unproven Procedures/Services	10/1/2021	
K1025	Non Pneum Compress Full Arm	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.032	Experimental, Investigational and/or Unproven Procedures/Services	10/1/2021	
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADIVI1001.032	Experimental, investigational and/or oriproven Procedures/Services	10/1/2021	_
K1027	Oral Dev Without Fix Mech	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	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders	10/1/2021	-
		predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	MED204.005	Diagnosis and Medical Management of Sleep Related Breathing Disorders  -	10/1/2021	-
L0999	Add To Spinal Orthosis Nos	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	MED204.005  -  -  DME103.002	Diagnosis and Medical Management of Sleep Related Breathing Disorders  -  -  Knee Braces	10/1/2021 - - -	- - -
L0999 L1499	Add To Spinal Orthosis Nos Spinal Orthosis Nos	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	-	-	10/1/2021 - - -	- - -
L1499 L1834	Add To Spinal Orthosis Nos  Spinal Orthosis Nos  Ko W/0 Joint Rigid Molded To	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed.	- - DME103.002	Knee Braces	10/1/2021 - - - -	- - - -
L1499 L1834 L1840	Add To Spinal Orthosis Nos  Spinal Orthosis Nos  Ko W/O Joint Rigid Molded To  Ko Derot Ant Cruciate Custom	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	- - DME103.002 DME103.002	Knee Braces Knee Braces	10/1/2021 - - - -	-
L1499 L1834 L1840 L1844 L1846	Add To Spinal Orthosis Nos  Spinal Orthosis Nos  Ko W/O Joint Rigid Molded To  Ko Derot Ant Cruciate Custom  Ko W/Adj Jt Rot Chtrl Molded  Ko W Adj Flex/Ext Rotat Mold	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe.  MI Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewe.  MI Criteria: Procedure/service net specifically defined or classified, maybe subject to	- DME103.002 DME103.002 DME103.002	- Knee Braces Knee Braces Knee Braces	10/1/2021 - - - -	- - - -
L1999 L1834 L1840 L1844 L1846 L2999	Add To Spinal Orthosis Nos  Spinal Orthosis Nos  Ko W/Ö Joint Rigid Molded To  Ko Derot Ant Cruciate Custom  Ko W/Adj Jt Rot Cntri Molded  Ko W Adj Flex/Ext Rotat Mold  Lower Extremity Orthosis Nos	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	- DME103.002 DME103.002 DME103.002	- Knee Braces Knee Braces Knee Braces	10/1/2021 - - - - -	-
L1999 L1834 L1840 L1844 L1846 L2999 L3040	Add To Spinal Orthosis Nos  Spinal Orthosis Nos  Ko W/O Joint Rigid Molded To  Ko Derot Ant Cruciate Custom  Ko W/Adj Jt Rot Cntrl Molded  Ko W Adj Flex/Ext Rotat Mold  Lower Extremity Orthosis Nos  Ft Arch Suprt Premold Longit	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	- DME103.002 DME103.002 DME103.002	- Knee Braces Knee Braces Knee Braces	10/1/2021	- - - - -
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1989   1989							
Section   Sect	L5780	Knee-Shin Pneum/Hydra Pneum	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	-	-
Second   S	L5816	Endo Knee-Shin Polyc Mch Sta		DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	_
SWAMERY         WATER STANDAMS OF	L5818	Endo Knee-Shin Frct Swg & St	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	
Second   S	15050	Stance Phase Only		DME104 012	Lower-Limb Procthatics Including Microprocessor-Controlled Procthatics		
March   Marc		•				-	
Wear	L5859	Knee-Shin Pro Flex/Ext Cont	predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	-	_
West	L5969	Ak/Ft Power Asst Incl Motors	predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	-	
Note	L5973	Ank-Foot Sys Dors-Plant Flex	predetermination to avoid post-service review.	DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	-	_
Section   Sect	L5978	Ft Prosth Multiaxial Ankl/Ft		DME104.012	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics	_	_
Second   Second Secon	L5999	Lowr Extremity Prosthes Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
Miles	L6026	Part Hand Myo Exclu Term Dev	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001		r	
Company   Comp						<u>-</u>	
No.   Control						- r	
Marie	L6621			DME104.001		_	
Mark	L6880	Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or		DME104.001		-	-
West							
Section   Sect	L6882	Microprocessor Control Uplmb		DME104.001		r _	_
Section   Sect	L6920	Wrist Disarticul Switch Ctrl	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	r _	_
	16925	Wrist Disart Mynelectronic C		DMF104 001		r	
West		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				r	
Marke   Mark			predetermination to avoid post-service review.		Lower-Limb Prosthesis	-	
Note	L6935	Below Elbow Myoelectronic Ct	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	_
West	L6940	Elbow Disarticulation Switch	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	_
Mater   Mate	L6945	Elbow Disart Myoelectronic C		DME104.001		_	_
	L6950	Above Elbow Switch Control	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	r _	_
Math   Mark	L6955	Above Elbow Myoelectronic Ct	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	r _	
	16960	Shidr Disartic Switch Contro		DMF104 001		r	
West						r	
	L6965	Shldr Disartic Myoelectronic	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	
	L6970	Interscapular-Thor Switch Ct	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	
Selection Control of Market Co	L6975	Interscap-Thor Myoelectronic		DME104.001			_
	L7007	Adult Electric Hand		DME104.001		r _	_
Mark Birth 1909   Modername to traverside protection and content and protection and protect	L7008	Pediatric Electric Hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104.001		r _	_
	L7009	Adult 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	r	
Policy Service No. 1	17040	Prehensile Actuator		DMF104 001		r	
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Wilson   Section   Secti						- r	
Math	L7170	Electronic Elbow Hosmer Swit	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	
Mathematical   Math	L7180	Electronic Elbow Sequential	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	_
Decision	L7181	Electronic Elbo Simultaneous		DME104.001		r _	_
Process   Proc	L7185	Electron Elbow Adolescent Sw		DME104.001			_
Public   District   Procedure   Procedur	L7186	Electron Elbow Child 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	r _	_
Service   Serv	17190	Fihow Adolescent Mygelectron		DMF104 001	Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	r	
Bettomic Winst Rotation Any   More Contract Procedural parties reflected places (control against Medical Policy Citeria, Submit for professional procession and pass service review.   DMELDAGO   DM		·					
Part		· · · · · · · · · · · · · · · · · · ·	predetermination to avoid post-service review.		Lower-Limb Prosthesis	-	
Procedure   Proc	L7259	Electronic Wrist Rotator Any		DME104.001	Lower-Limb Prosthesis		_
Table   Twelve Volt Battery Utaly/Equ   MP Ciferia: Procedure/service reviewed against Medical Policy Ciferia. Submit for predetermination to acod post-service review.   MP Ciferia: Procedure/service reviewed against Medical Policy Ciferia. Submit for predetermination to acod post-service review.   MP Ciferia: Procedure/service reviewed against Medical Policy Ciferia. Submit for predetermination to acod post-service review.   MP Ciferia: Procedure/service review.   MP Ciferia: Pr	L7360	Six Volt Bat Otto Bock/Eq Ea			Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	r _	_
Line	17264	Total or Male Base 1997 199	,			r	
Saftery Cirgy 12 Yorl Utahy    predetermination to avoid post-service review.   DME104.001   Lower-Limb Prosthesis			predetermination to avoid post-service review.		Lower-Limb Prosthesis	-	_
Separat Prosthesis Nos   Contract/clinical review.   -   -   -   -   -   -   -   -   -	L7366	Battery Chrgr 12 Volt Utah/E	predetermination to avoid post-service review.	DME104.001		-	_
Second   S	L7499	Upper Extremity Prosthes Nos	contract/clinical review.	-	-	-	-
Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  18499 Unisted Misc Prosthetic Ser Unisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.  18500 Implant Breast Silicone/Eq	L8039	Breast Prosthesis Nos		-	-	-	_
Lab9 Unlisted Misc Prosthetics er Contract/Clinical review	L8048	Unspec Maxillofacial Prosth	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
Before   Implant Breast Silicone/fq   MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require prior Authorization per contract agreement.   SuR716.009 SuR716.010 SuR71	L8499	Unlisted Misc Prosthetic Ser	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_		_	
Habou Implant Breast Silicone/Eq Prior Authorization per contract agreement.  Beog Collagen Imp Urinary 2.5 Ml PCriteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Beog Dextranomer/Hyaluronic Acid  Big Dextranomer/Hyaluronic Acid  Big Dextranomer/Hyaluronic Acid  Mp Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Beog Dextranomer/Hyaluronic Acid  Big Dextranomer/Hyaluronic Acid  Mp Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Dextranomer/Hyaluronic Acid  Mp Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for preservice review.  Big Div Procedure/service reviewed against Medical Policy Criteria. Submit for preservice			concracy Clinical review.	SUR716 009	Breast Implant, Removal and/or Insertion		
Reformation to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Reformation to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Reformation to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.  Reformation to	L8600	Implant Breast Silicone/Eq		SUR716.010 SUR716.011	Reconstructive and Contralateral Mammaplasty  Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for	, -	-
Before   Perture territorial production to avoid post-service review.   SUR/10.002   Perture teral Bulking Agents for the Treatment of Virinary and Fecal Incontinence	L8603	Collagen Imp Urinary 2.5 Ml			Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	_	_
Pediatromery/nyauronical predetermination to avoid post-service review.   SUR710.022   Perioreteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)						-	
In Bulking Agent Anal Canal   Check EU policy CPCP028, which is one of our Clinical Payment and Coding Policy CPCP028, which is one of our Clinical Payment and Coding Policy CPCP028, which is one of our Clinical Payment and Coding Policy CPCP028, which is one of our Clinical Payment and Coding Policy CPCP028, which is one of our Clinical Policy Criteria. Submit for predetermination to avoid post-service review.    R8606   Synthetic Implitt Urinary 1MI   Forestiment of Urinary and Fecal Incontinence	LOUGH	Sextranomer/nyaluronic Acid	predetermination to avoid post-service review.				_
Synthetic Impinit Urinary 1MI B066 Arg ii Ext Com/Sup/Acc Misc (CPC):    B608   Arg ii Ext Com/Sup/Acc Misc (CPC):   B612   Aguenus Shurt Prosthesis   MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SUR710.028 Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence   Perfureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)	L8605	Inj Bulking Agent Anal Canal	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	-	-
SUR710.022 Perfureteral Butking Agents as a Treatment of Vesicoureteral Retiux (VUK)  EIU: Procedure/service not reinbursed by the Plan. Not subject to pre-service review.  18608 Arg Ii Ext Com/Sup/Acc Misc Check Elly policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  (CPCP):  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SIB713.024 Aguenus Shurth and Stents for Glaucoma.	L8606	Synthetic Implnt Urinary 1MI	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for \$18713, 024. Anyonus Shunts and Stents for Glauroma.			EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.			-	_
			(CPCP).			-	-
	L8012	Aqueous Snunt Prosthesis		3UK/13.U34	Aqueous situnts and Stents for Glaucoma	-	

Model         Model of Model Section (Model Section Se							
Second	L8614	Cochlear Device		SUR714.004	Cochlear Implant	-	-
Second	L8615	Coch Implant Headset Replace		SUR714.004	Cochlear Implant	-	_
Second   S	L8616	Coch Implant Microphone Repl		SUR714.004	Cochlear Implant	-	-
Section   Sect	L8617	Coch Implant Trans Coil Repl		SUR714.004	Cochlear Implant	-	_
80         60         Control of Section 1988         Control of Sect	L8618	Coch Implant Tran Cable Repl		SUR714.004	Cochlear Implant	_	_
Sile of the color of	L8619	Coch Imp Ext Proc/Contr Rplc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
Side Side 1         Machine of Machine Side Side Side Side Side Side Side Sid	L8621	Repl Zinc Air Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
See	L8622	Repl Alkaline Battery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
Series of Series	L8623	Lith Ion Batt Cid Non-Earlyl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
See	L8624	Lith Ion Batt Cid Ear Level	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
	L8627	Cid Ext Speech Process Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
March   Marc	L8628	Cid Ext Controller Repl	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant	_	_
	L8629	Cid Transmit Coil And Cable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	SUR714.004	Cochlear Implant		
			MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require			-	-
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1988   1988		, ,	predetermination to avoid post-service review.		· · · · · · · · · · · · · · · · · · ·	_	
Western   West			predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	_	_
Series of Series	L8699	Prosthetic Implant Nos	contract/clinical review.	-		-	-
March   Marc	L8701	Ewh S/D Uprt Micro Sensor	predetermination to avoid post-service review.	DME104.001	Lower-Limb Prosthesis	-	_
Section   Sect	L8702	Ewhf S/D Uprt Micro Sensor	predetermination to avoid post-service review.	DME104.001			-
Marie   Mari	M0075	Cellular Therapy	review.	_	-	_	-
	M0100	Intragastric Hypothermia	review.	-	-	-	-
	M0239	bamlanivimab-xxxx infusion		-	-	4/16/2021	
Section   Content   Cont	M0301	Fabric Wrapping Of Aneurysm		_	-	_	_
See the second processed p	P2028	Cephalin Floculation Test		_	-	_	_
March   Marc	P2029	Congo Red Blood Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
Second   S	P2031	Hair Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	PSY301.014	Autism Spectrum Disorders (ASD)	_	_
Part of the Control Processes of the Control P	P2033	Blood Thymol Turbidity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
Part	P2038	Blood Mucoprotein	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
	P9020	Plaelet Rich Plasma Unit	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy		Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-	_	_
Section   Sect	P9099	Blood Component/Product Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to		Orthopedic Conditions		
Contact of an interface of the Park All and involved of the Park All and i	Q0239	Bamlanivimab-Xxxx	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>	_	9/30/2021
Control   Cont					<u>-</u>	-	.,.,
Marianimal And Estevies Reconstruction of Section 1997 (2014) (1997) (19					<u>-</u>	6/2/2021	-
Per Modelle Fic Cale Vasil By 10 Per Modelle Fic Vasil By 10 Per Modelle Fic Vasil By 10 Per Fic Fic Vasil By				-	-		-
MC Contact Product Pro	-			-	-	2/9/2021	-
Monitor Etc Or Combine Management of the analysis of the combine Management Medical Policy (riteria, submit for Managem							-
Series of the first of the firs			predetermination to avoid post-service review.			-	_
Section   Sect	Q0484		predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
pedetermination to avide post-service review.  SIRPO DT 1  SIRPO D	Q0485	Monitor Cable Elec Vad Rep	predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	_	_
predetermination to awoid post-service review.  Sincy District Services and Total Artificial Hearts  Province Flex Vad Rep Province	Q0487	Leads Any Type Vad Rep Only	predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts		_
Sur Pur Course   Ferritary	Q0488	Pwr Pack Base Elec Vad Rep	predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	_	_
Company   Comp	Q0489	Pwr Pck Base Combo Vad Rep	predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
Comparison   Com	Q0490	Emr Pwr Source Elec Vad Rep	predetermination to avoid post-service review.	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   SUR70.017   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   SUR70.017   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   SUR70.017   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   SUR70.017   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   SUR70.017   SUR70.017   Ventricular Assist Devices and Total Artificial Hearts   Ventricular Assist Devices and Total Artificial	Q0491	Emr Pwr Source Combo Vad Rep		SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed.   Post-predetermination to avoid post-service reviewed. Against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service reviewed against Medical	Q0492	Emr Pwr Cbl Elec Vad Rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
No price of the minute of the	Q0493	Emr Pwr Cbl Combo Vad Rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	-
MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed.  MR M Criteria: Procedure/service review.  MR M Criteria: Submit fo	Q0494	Emr Hd Pmp Elec/Combo Rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	-	_
MoSof Pwr Adpt Pneum Vad Rep Val Porcedure/Service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.  SUR70.017 Ventricular Assist Devices and Total Artificial Hearts	Q0500	Filters Elec/Combo Vad Rep	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts	_	_
Predetermination to avoid post-service review.   Predetermination to avoid post-serv	Q0504	Pwr Adpt Pneum Vad Rep Veh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.017	Ventricular Assist Devices and Total Artificial Hearts		_
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Use Fee Antiem Antical Immuno  OD511 Sup Fee Antiem Antical Immuno  OD512 Px Sup Fee Anti-Can Sub Pres  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  Non Covere			contract/clinical review.	-	-	-	-
QUS1 Sup Fee Antien Antica Immuno review.  Q0512 Px Sup Fee Anti-Can Sub Pres Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for SuB216 Sealies to Injection MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			review.	-	-	-	-
QU512 PX SUP FEE ARTH-Lan Sup Pres  review		.,	review.	-	-	-	-
			review.	-	-	-	-
	Q2026	Radiesse Injection		SUR716.001	Cosmetic and Reconstructive Procedures	_	_

Q2028	Inj Sculptra 0.5Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.001	Cosmetic and Reconstructive Procedures	-	-
Q2039	Influenza Virus Vaccine Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
Q2041	Axicabtagene Ciloleucel Car+	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.088	Chimeric Antigen Receptor (CAR) T-cell Therapy	_	_
Q2042	Tisagenlecleucel Car-Pos T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.088	Chimeric Antigen Receptor (CAR) T-cell Therapy	-	_
	Sipuleucel-T Minimum Of 50	The national of per conduct of centers.				
Q2043	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.	RX501.074	Cellular Immunotherapy for Prostate Cancer (Sipuleucel-T [Provenge])	-	10/10/2021
Q2050	Doxorubicin Inj 10Mg	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
Q2053	Brexucabtagene car pos t	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	4/1/2021	_
Q2054	Lisocabtagene Mara Car Pos T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX502.061	Oncology Medications	10/1/2021	_
Q4050	Cast Supplies Unlisted	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_		_	_
Q4051	Splint Supplies Misc	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		
Q4082	Drug/Bio Noc Part B Drug Cap	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		_
Q4100	Skin Substitute Nos	review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		-	-	-
Q4100	Skill Substitute Nos	contract/clinical review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	-	-	-
Q4103	Oasis Burn Matrix	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 review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4104	Integra Bmwd	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4110	Primatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4111	Gammagraft	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4112	Cymetra Injectable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4113	Graftjacket Xpress	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4115	Alloskin	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4118	Matristem Micromatrix	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4121	Theraskin	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4122	Dermacell, Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	_
Q4123	Alloskin Rt Per Square Centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4124	Oasis Ultra Tri-Layer Wound	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4125	Matrix Per Square Centimeter  Arthroflex Per Square Centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
Q4126	Memoderm/Derma/Tranz/Integu p	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 review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4127	Talymed Per Square Centimeter	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4130	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4132	Grafix core grafixpl core	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4133	Grafix stravix prime pl sqcm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	_
Q4134	Hmatrix	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, 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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4137	Amnioexcel Biodexcel 1Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP)	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4138	Biodfence Dryflex 1Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4139	Amnio Or Biodmatrix Inj 1Cc	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4140	Biodfence 1Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4141	Alloskin Ac 1 Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4142	Xcm Biologic Tiss Matrix 1Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
Q4143	Repriza 1Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	
21113		(CPCP).	-3		-,,,,	-

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Q4145	Epifix Inj 1Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4146	Tensix 1Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4147	Architect Ecm Px Fx 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4148	Neox Neox Rt Or Clarix Cord	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4150	Allowrap Ds Or Dry 1 Sq Cm	EIU. Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4151	Amnioband guardian 1 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	_
Q4152	Dermapure 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4153	Dermavest Plurivest Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	-
Q4154	Biovance 1 square cm	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	_
Q4155	Neoxflo Or Clarixflo 1 Mg	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid		_
Q4155	Neoxilo Of Clarixilo 1 Mg	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 review.	308704.011	Annious wemorane and Annious Fluid	-	-
Q4156	Neox 100 Or Clarix 99	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 review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4157	Revitalon 1 Square Cm	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4159	Affinity1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4160	Nushield 1 Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4161	Bio-Connekt Per Square Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4162	Wndex Flw Bioskn Flw 0.5Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4164	Helicoll Per Square Cm	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bloengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4165	Keramatrix Kerasorb Sq Cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4166	Cytal Per Square Centimeter	EUL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	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 CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4168	Amnioband 1 mg	(CPCP). MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	_
Q4169	Artacent Wound Per Sq Cm	predetermination to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		
Q4170	Cvenus Per Sa Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				-
Q4171	Interfyl 1 Mg	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4174	Palingen Or Promatrx	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4175	Miroderm, Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	4/1/2021	-
Q4176	Neopatch Or Therion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4178	Floweramniopatch Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4179	Flowerderm Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4180	Revita Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4181	Amnio Wound Per Square Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4182	Transcyte Per Sq Centimeter	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4183	Surgigraft 1 Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4184	Cellesta Or Duo Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		
		(CPCP).			-	

		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
Q4185	Cellesta Flowab Amnion 0.5Cc	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4186	Epifix 1 sq cm	predetermination to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	08/15/2021	-
Q4188	Amnioarmor 1 Sq Cm	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4189	Artacent Ac 1 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4190	Artacent Ac 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4191	Restorigin 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4192	Restorigin 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4193	Coll-E-Derm 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4194	Novachor 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4195	Puraply 1 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	-	5/14/2021
Q4195	Puraply 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4196	Puraply Am 1 Sq Cm	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	_	5/14/2021
Q4196	Puraply Am 1 Sq Cm	Ellu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4197	Puraply Xt 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	-	-
Q4198	Genesis Amnio Membrane 1Sqcm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4200	Skin Te 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4201	Matrion 1 Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4202	Keroxx (2.5G/Cc) 1Cc	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4203	Derma-Gide 1 Sq Cm	EU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4204	Xwrap 1 Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4205	Membrane Graft Or Wrap Sq Cm	Ellu: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4206	Fluid Flow Or Fluid Gf 1 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4208	Novafix Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4209	Surgraft Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4210	Axoloti Graf Dualgraf Sq Cm	EIU. Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4211	Amnion Bio Or Axobio Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4212	Allogen Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4213	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4214	Cellesta Cord Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	-
Q4215	Axolotl Ambient Cryo 0.1 Mg	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4216	Artacent Cord Per Sq Cm	[CPCP].  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4217	Woundfix Biowound Plus Xplus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4218	Surgicord Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4219	Surgigraft Dual Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	_
Q4220	Bellacell Hd Surederm Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	-
Q4221	Amniowrap2 Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4222	Progenamatrix Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.012	Bioengineered Skin and Soft Tissue Substitutes	5/15/2021	_
Q4227	Amniocore Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4228	Bionextpatch Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		9/30/2021
		(CPCP).			-	

Q4229	Cogenex Amnio Memb Per Sq Cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4230		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding 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 CPCP028, 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 CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4233		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4234	Xcellerate Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	-
Q4235	Amniorenair Or Altinly Per	(CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
Q4236	Caranatch Par Squara	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		9/30/2021
Q4237	Cryo-Cord Per Square	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid		_
	Amnio-Maxx Or Amnio-Maxx	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
Q4239	Lite, Per	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 review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4240	Per	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 review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4241	Polycyte, For Topical Use Only, Per	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4242	Amniocyte Plus, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4244	Procenta, Per 200 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4245	Amniotext, Per Cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4246		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4247	Amniotext Patch, Per Square Centime	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4248		Ell: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check ElU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	-	-
Q4249		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding 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 CPCP028, which is one of our Clinical Payment and Coding Policy  (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4251		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	_
Q4251		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4252	Vendaje Per Square Centimet	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR704.011	Amniotic Membrane and Amniotic Fluid	10/1/2021	_
Q4252		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	-
Q4253	Zenith Amniotic Membrane Psc	(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	_
Q4253	Zenith Amniotic Membrane Psc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2022	_
Q4254	Novafix DI Per Sq Cm	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q4255	Reguard Topical Use Per Sq	(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR704.011	Amniotic Membrane and Amniotic Fluid	3/1/2021	-
Q5009	Hospice Care Nos	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
Q5103	Injection Inflectra	contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.051	- Infliximab and Associated Biosimilars		
		Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	RX501.096 RX501.051	Specialty Medication Administration Site of Care Infliximab and Associated Biosimilars	<del>-</del>	
Q5104	Injection Renflexis	Prior Authorization per contract agreement.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.096	Specialty Medication Administration Site of Care	-	-
Q5106	Inj Retacrit Non-Esrd Use	predetermination to avoid post-service reviewe.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.069	Erythropoiesis-Stimulating Agents (ESAs)	-	_
Q5107	Inj Mvasi 10 Mg	predetermination to avoid post-service review.	RX502.061	Oncology Medications	-	10/10/2021
Q5109	Injection Ixifi 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.051	Infliximab and Associated Biosimilars	_	_
Q5115	Inj Truxima 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. 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.	RX502.061	Oncology Medications	-	10/10/2021
Q5119	Inj Ruxience 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	_	10/10/2021
Q5123	Inj. riabni 10 mg	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX502.030	Rituximab and Biosimilars for Non-Oncologic Indications	7/1/2021	10/10/2021
S0013	Esketamine Nasal Spray	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	RX501.105	Esketamine Nasal Spray	2/1/2021	
		predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-/ -/ -/	-
S0117	Tretinoin Topical 5 G	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S0142	Colistimethate Inh Sol Mg	review.	-	-	-	-
S0155	Epoprostenol Dilutant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.056	Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension	-	_
S0157	Becaplermin Gel 1% 0.5 Gm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non- Orthopedic Conditions	-	-
S0189	Testosterone Pellet 75 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require Prior Authorization per contract agreement.	SUR717.001 RX501.007 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies	-	-

		No. County Described for the state of the No. Not which the state of t				
S0197	Prenatal Vitamins 30 Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	F. Control of the con	-	-
S0209	Wc Van Mileage Per Mi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
S0215	Nonemerg Transp Mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.005	Ambulance and Medical Transport Services	_	_
50310	Haspitalist Visit	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_	
S0310	Hospitalist Visit	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	-
S0320	Rn Telephone Calls To Dmp	review.	-	-	-	-
S0590	Misc Integral Lens Serv	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
S0622	Phys Exam For College	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
50800	Laser In Situ Keratomileusis	review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR713.001	Refractive and Therapeutic Keratoplasty		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	_
S0810	Photorefractive Keratectomy	predetermination to avoid post-service review.	SUR713.001	Refractive and Therapeutic Keratoplasty	-	-
S1001	Deluxe Item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
S1002	Custom Item	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
S1030	Gluc Monitor Purchase	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME101.005	Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for			_	
S1031	Gluc Monitor Rental	predetermination to avoid post-service review.	DME101.005	Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes	_	_
S1040	Cranial Remolding Orthosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	DME103.007	Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses	-	-
S2068	Breast Diep Or Siea Flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR716.011	Reconstructive and Contralateral Mammaplasty	_	_
S2083	Adjustment Gastric Band	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR716.003	Bariatric Surgery		
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		<del>-</del> ·		
S2103	Adrenal Tissue Transplant	predetermination to avoid post-service review.	SUR703.003	Brain Tissue Transplantation and Neurotransplantation	-	-
S2117	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding 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 Lipoprotein(Ldl)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria, may require	THE802.003	Lipid Apheresis		
		Prior Authorization per contract agreement.		-pur pura-	_	-
\$2140	Cord Blood Harvesting	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR703.037 SUR703.002 SUR703.003 SUR703.047 SUR703.047 SUR703.045 SUR703.038 SUR703.039 SUR703.039 SUR703.041 SUR703.041 SUR703.041 SUR703.034 SUR703.035 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.045 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.055 SUR703.066	Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (Genera Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Aquired Immunodeficiency Syndrome (AIDS) Hematopoietic Cell Transplantation for Envirol Mematopoietic 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 Fibribelial Ovarian Cancer 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 Moscellaneous 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 Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Macroglobulinemia Hematopoietic Cell Transplantation for Macroglobulinemia Hematopoietic Cell Transplantation for Macroglobulinemia	-	-
\$2142	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 SUR703.045 SUR703.036 SUR703.039 SUR703.029 SUR703.041 SUR703.034 SUR703.035 SUR703.035 SUR703.040 SUR703.040 SUR703.040 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 (Genera Donor and Recipient Information) Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for Aquired 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 (SLLL) 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 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 Pismar Systemic Amyloidosis Hematopoietic Cell Transplantation for Pirmary Systemic Amyloidosis Hematopoietic Cell Transplantation for Millon Tumors in Children	-	-

				Harman and the Cell Transplantation for Aside Mariana and Laurente (AMI)		
				Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)  Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General		
			SUR703.037	Donor and Recipient Information)		
			SUR703.002 SUR703.043	Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)  Hematopoietic Cell Transplantation for Acquired Immunodeficiency Syndrome (AIDS)		
			SUR703.047	Hematopoietic Cell Transplantation for Autoimmune Diseases		
			SUR703.036	Hematopoietic Cell Transplantation for Breast Cancer		
			SUR703.038 SUR703.039	Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic		
			SUR703.029	Lymphoma (SLL)		
			SUR703.041	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia		
S2150	Bmt Harv/Transpl 28D Pkg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR703.034 SUR703.033	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer  Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias		
	, ,	predetermination to avoid post-service review.	SUR703.040	Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)	-	-
			SUR703.042 SUR703.035	Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas  Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults		
			SUR703.032	Hematopoietic Cell Transplantation for Myelodysplastic Syndromes (MDS) and Myeloproliferative		
			SUR703.031	Neoplasms (MPN)		
			SUR703.030 SUR703.046	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas  Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma (MM) and		
			SUR703.044	POEMS Syndrome		
			SUR703.050 SUR703.045	Hematopoietic Cell Transplantation for Primary Systemic Amyloidosis Hematopoietic Cell Transplantation for Solid Tumors in Children		
				Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia		
				Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors		
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.016	Varicose Vein Management		
32202	Echoscierotherapy	predetermination to avoid post-service review.	30K/07.016	varicose vein management	-	_
S2205	Minimally Invasive Direct Co	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery	-	-
S2206	Minimally Invasive Direct Co	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery		
	<u> </u>	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for		minimally invalve colonial y vicely bypass or all saligery		
S2207	Minimally Invasive Direct Co	predetermination to avoid post-service review.	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery	_	_
S2208	Minimally Invasive Direct Co	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery	_	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
S2209	Minimally Invasive Direct Co	predetermination to avoid post-service review.	SUR707.020	Minimally Invasive Coronary Artery Bypass Graft Surgery	-	-
S2230	Implant Semi-Imp Hear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	_	_
62225	Local and Acaditana Davida Lava	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	CUD74 4 000	A. Jihan Parlankan Inglank		
S2235	Implant Auditory Brain Imp	predetermination to avoid post-service review.	SUR714.009	Auditory Brainstem Implant	-	_
S2300	Arthroscopy Shoulder Surgi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	SUR705.041	Thermal Capsulorrhaphy as a Treatment of Joint Instability		
32300	Artifoscopy Shoulder Surgi	(CPCP).	301703.041	Thermal Capadion hapity as a Treatment of Joint Instability	-	-
S2400	Fetal Surg Congen Hernia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	_	_
		predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for				
S2403	Fetal Surg Pulmon Sequest	predetermination to avoid post-service review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	-	-
S2405	Fetal Surg Sacrococ Teratoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR701.016	Fetal Surgery for Prenatally Diagnosed Malformations	_	_
S2409	Fetal Surg Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
32403	Tetal Suig Noc	contract/clinical review.	-	-	-	_
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.  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	-	<u>-</u>	-	-
S3650	Saliva Test Hormone Level;	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.128	Salivary Hormone Testing	_	_
		(CPCP).  EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
S3652	Saliva Test Hormone Level;	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED207.128	Salivary Hormone Testing	_	_
		(CPCP).			_	
S3900	Surface Emg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED205.006	Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy		
		(CPCP).			-	-
S4015	Complete Ivf Nos Case Rate	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
		contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S4023	Incompl Donor Egg Case Rate	review.	-	<u>-</u>	-	-
S4025	Donor Serv lvf Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
S4026	Procure Donor Sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
34026	Procure bollor sperill	review.	-	-	-	-
S4027	Store Prev Froz Embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S4030	Sperm Procure Init Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			-	-
S4031	Sperm Procure Subs Visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S4040	Monit Store Cryo Embryo 30 D	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service			_	
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		
\$4990	Nicotine Patch Legend	review.	-	-	-	-
S4991	Nicotine Patch Nonlegend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	_
C400F	Constitute	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S4995	Smoking Cessation Gum	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				
22020	t Device Kepail	review.	-	-	-	-
S5100	Adult Daycare Services 15Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5101	Adult Day Care Per Half Day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5102	Adult Day Care Per Diem	review.	-	-	-	-
S5105	Centerbased Day Care Perdiem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
	· · · · · · · · · · · · · · · · · · ·	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5108	Homecare Train Pt 15 Min	review.	-	-	-	-
S5109	Homecare Train Pt Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
\$5110	Family Homosoro Training 451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5110	Family Homecare Training 15M	review.	-	-	-	-
S5111	Family Homecare Train/Sessio	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5115	Nonfamily Homecare Train/15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5116	Nonfamily Hc Train/Session	review.	-	-	-	-
S5120	Chore Services Per 15 Min	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	
		review.				

S5121	Chore Services Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5125	Attendant Care Service /15M	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S5126	Attendant Care Service /Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
S5130	Homaker Service Nos Per 15M	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S5131	Homemaker Service Nos /Diem	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	<del>-</del>		_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	-
S5135	Adult Companioncare Per 15M	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5136	Adult Companioncare Per Diem	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	_	_	_	_
S5150	Unskilled Respite Care /15M	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
	<u> </u>	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	_
S5151	Unskilled Respitecare /Diem	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	_
S5160	Emer Response Sys Instal&Tst	review.	-	-	-	-
S5161	Emer Rspns Sys Serv Permonth	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5162	Emer Rspns System Purchase	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	-	_
S5165	Home Modifications Per Serv	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S5170	Homedelivered Prepared Meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	_	_
S5175	Laundry Serv Ext Prof /Order	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
		review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-		_
S5181	Hh Respiratory Thrpy Nos/Day	contract/clinical review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S5185	Med Reminder Serv Per Month	review.	-	-	-	-
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S5497	Hit Cath Care Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	PSY301.014 RAD601.038	Autism Spectrum Disorders (ASD) Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)	_	_
50430	Interferential Current Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
S8130	2 Channel	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	MED201.041	Interferential Current Stimulation	-	-
S8131	Interferential Current Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.  Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	MED201.041	Interferential Current Stimulation	_	_
	4 Channel	(CPCP). Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
S8189	Trach Supply Noc	contract/clinical review.	-	-	-	-
S8270	Enuresis Alarm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S8301	Infect Control Supplies Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
S8460	Camisole Post-Mast	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
S8930	Auricular Electrostimulation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.				
S8940	Hippotherapy Per Session	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	THE803.022	Hippotherapy	-	-
		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	THE801.028 SUR702.005	Acne Management Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence		
S8948	Low-Level Laser Trmt 15 Min	predetermination to avoid post-service review.	MED201.045 MED205.022	Low-Level and High-Power Laser Therapy	-	-
		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.		Treatment of Tinnitus		
S9001	Home Uterine Monitor With Or	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	OB401.017	Home Uterine Activity Monitoring	-	-
S9055	Procuren Or Other Growth Fac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.034	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non- Orthopedic Conditions	_	_
S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review.	MED205.014			
39030	Coma Stillidiation Per Diem	Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP).	WED203.014	Sensory Stimulation for Coma Patients	-	-
S9090	Vertebral Axial Decompressio	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy	THE803.021	Non-Surgical Spinal Decompression Traction Devices	_	_
50435		(CPCP).  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9125	Respite Care In The Home P	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
S9379	Hit Noc Per Diem	contract/clinical review.	-	-	-	-
S9381	Hit High Risk/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	-
S9436	Lamaze Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
S9437	Childbirth Refresher Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	-
S9438	Cesarean Birth Class	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
S9439	Vbac Class	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9442		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-	-	-
-	Birthing Class	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S9444	Parenting Class	review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
S9445	Pt Education Noc Individ	contract/clinical review.	-	-	-	-
S9446	Pt Education Noc Group	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	-
S9447	Infant Safety Class	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	_	-	_	_
S9451	Exercise Class	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	_	_	_
S9454	Stress Mgmt Class	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		-		
		review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	- TUE002.000	Condition Balanchilleration (CD)	-	-
S9472	Cardiac Rehabilitation Progr	predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	THE803.023	Cardiac Rehabilitation (CR)	-	-
S9482	Family Stabilization 15 Min	review.	-	-	-	-

		Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
S9542	Ht Inj Noc Per Diem	contract/clinical review.	-	-	-	-
S9558	Ht Inj Growth Horm Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.040	Human Growth Hormone (GH)	-	_
S9560	Ht Inj Hormone Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	RX501.041	Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists	_	_
S9810	Ht Pharm Per Hour	Unlisted: Procedure/service not specifically defined or classified, maybe 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.	_	_	_	_
S9960	Air Ambulanc Nonemerg Fixed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.005	Ambulance and Medical Transport Services		
S9961	Air Ambulan Nonemerg Rotary	predetermination to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	ADM1001.005	Ambulance and Medical Transport Services		
		predetermination to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	ADM1001.005	Ambulance and Medical Transport Services	-	_
S9970	Health Club Membership Yr	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	_
S9975	Transplant Related Per Diem	review.	-	-	-	-
S9976	Lodging Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S9977	Meals Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S9981	Med Record Copy Admin	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
S9982	Med Record Copy Per Page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9986	Not Medically Necessary Svc	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service		<u>-</u>		_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S9988	Serv Part Of Phase I Trial	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	-	-
S9990	Services Provided As Part Of	review.	-	-	-	-
S9991	Services Provided As Part Of	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	-	_
S9992	Transportation Costs To And	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	-	_	_
S9994	Lodging Costs (E.G. Hotel Ch	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	_	_	_	_
S9996	Meals For Clinical Trial Par	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service				
S9999	Sales Tax	review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	-	-	_	_
		review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service	_	-	-	-
T1014	Telehealth Transmit Per Min	review.	-	-	-	-
T1505	Elec Med Comp Dev Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
T1999	Noc Retail Items Andsupplies	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	_	-	_
T2012	Habil Ed Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
T2013	Habil Ed Waiver Per Hour	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
T2014	Habil Prevoc Waiver Per D	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
T2015	Habil Prevoc Waiver Per Hr	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	<u>-</u>	_	_
T2016	Habil Res Waiver Per Diem	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
T2017	Habil Res Waiver 15 Min	contract/clinical review.	-	-	-	-
T2018	Habil Sup Empl Waiver/Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
T2019	Habil Sup Empl Waiver 15Min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	_	_	_
T2020	Day Habil Waiver Per Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
T2021	Day Habil Waiver Per 15 Min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
T2024	Serv Asmnt/Care Plan Waiver	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to		<u>-</u>		_
		contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	-	-
T2025	Waiver Service Nos	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	-	-
T2026	Special Childcare Waiver/D	contract/clinical review.	-	-	-	-
T2027	Spec Childcare Waiver 15 Min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
T2028	Special Supply Nos Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
T2029	Special Med Equip Noswaiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
T2030	Assist Living Waiver/Month	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	_	_	_
T2031	Assist Living Waiver/Diem	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to			-	
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
T2032	Res Care Nos Waiver/Month	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	-
T2033	Res Nos Waiver Per Diem	contract/clinical review.	-	-	-	-
T2034	Crisis Interven Waiver/Diem	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
T2035	Utility Services Waiver	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
T2036	Camp Overnite Waiver/Session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	_	_
T2037	Camp Day Waiver/Session	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
T2038	Comm Trans Waiver/Service	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
		contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	-	_
T2039	Vehicle Mod Waiver/Service	contract/clinical review. Unlisted: Procedure/service not specifically defined or classified, maybe subject to	-	-	=	-
T2040	Financial Mgt Waiver/15Min	contract/clinical review.	-	-	-	-
T2041	Support Broker Waiver/15 Min	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	_
T5999	Supply Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	_	-	-	_
V2025	Eyeglasses Delux Frames	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	_
V2199	Lens Single Vision Not Oth C	Unlisted: Procedure/service not specifically defined or classified, maybe subject to	_	-	_	_
V2599	Contact Lens/Es Other Type	contract/clinical review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to				
		contract/clinical review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for	DME104 002	Therapautic Lancer, Sclaral Shall	-	-
V2627	Scleral Cover Shell	predetermination to avoid post-service review.  Unlisted: Procedure/service not specifically defined or classified, maybe subject to	DME104.003	Therapeutic Lenses, Scleral Shell	-	-
V2629	Prosthetic Eye Other Type	contract/clinical review.	-	-	-	-

V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
V2744	Tint Photochromatic Lens/Es	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	-	-
V2788	Presbyopia-Correct Function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	-	-
V2799	Misc Vision Item Or Service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	-	-	_	-
V5090	Hearing Aid Dispensing Fee	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	-
V5095	Implant Mid Ear Hearing Pros	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review.	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	_	-
V5267	Hearing Aid Sup/Access/Dev	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
V5274	Ald Unspecified	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	-
V5287	Ald Fm/Dm Receiver Nos	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
V5298	Hearing Aid Noc	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	-	-
V5299	Hearing Service	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review.	-	-	_	_

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