



2024 Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered Procedure Code List - Administrative Services Only (ASO) Accounts Effective 1/1/2024

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| <p>This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes related to services/categories for which prior authorization may be required as of January 1, 2024 unless otherwise indicated through Blue Cross and Blue Shield of New Mexico managed for one or more of our networks:</p> <ul style="list-style-type: none"> - PPOSM -Blue Preferred EPO -Blue Preferred Plus -HMO | <p>Utilization Management Process</p> <p>This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.</p> |
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| Procedure Code Groups | Procedure Code Group Description |
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| Medical Policy Criteria (MP Criteria) | <p>Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.</p> <p>Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.</p> |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). |
| Unlisted or Undefined | Procedures/services not specifically defined or classified, may be subject to contract/clinical review. |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date | Updates |
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| 00640 | ANESTH SPINE MANIPULATION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 00797 | ANESTH SURGERY FOR OBESITY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 07957 | Weight Loss | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 11200 | REMOVAL OF SKIN TAGS <W/15 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| 11201 | REMOVE SKIN TAGS ADD-ON | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 11920 | Correct Skin Color 6.0 Cm/< | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11921 | Correct Skn Color 6.1-20.0Cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11922 | Correct Skin Color Ea 20.0Cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11950 | TX CONTOUR DEFECTS 1 CC/< | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11951 | TX CONTOUR DEFECTS 1.1-5.0CC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11952 | TX CONTOUR DEFECTS 5.1-10CC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11954 | TX CONTOUR DEFECTS >10.0 CC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11960 | INSERT TISSUE EXPANDER(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11970 | RPLCMT TISS XPNDR PERM IMPLT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 11980 | IMPLANT HORMONE PELLE(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15271 | Skin Sub Graft Trnk/Arm/Leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |

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| 15272 | Skin Sub Graft T/A/L Add-On | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15273 | Skin Sub Grft T/Arm/Lg Child | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15274 | Skn Sub Grft T/A/L Child Add | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15275 | Skin Sub Graft Face/Nk/Hf/G | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15276 | Skin Sub Graft F/N/Hf/G Addl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15277 | Skn Sub Grft F/N/Hf/G Child | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15278 | Skn Sub Grft F/N/Hf/G Ch Add | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| 15758 | FREE FASCIAL FLAP MICROVASC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15769 | GRFG AUTOL SOFT TISS DIR EXC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15771 | GRFG AUTOL FAT LIPO 50 CC/< | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15772 | GRFG AUTOL FAT LIPO EA ADDL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 15775 | HAIR TRNSPL 1-15 PUNCH GRFTS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15776 | HAIR TRNSPL >15 PUNCH GRAFTS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15780 | DERMABRASION TOTAL FACE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15781 | DERMABRASION SEGMENTAL FACE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15782 | DERMABRASION OTHER THAN FACE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15783 | DERMABRASION SUPRFL ANY SITE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15786 | ABRASION LESION SINGLE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15787 | ABRASION LESIONS ADD-ON | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15788 | CHEMICAL PEEL FACE EPIDERM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15789 | CHEMICAL PEEL FACE DERMAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15792 | CHEMICAL PEEL NONFACIAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 15793 | CHEMICAL PEEL NONFACIAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15820 | REVISION OF LOWER EYELID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15821 | REVISION OF LOWER EYELID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15822 | REVISION OF UPPER EYELID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15823 | REVISION OF UPPER EYELID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15824 | REMOVAL OF FOREHEAD WRINKLES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | 1/31/2024 | Retire effective 01/31/2024 |
| 15825 | REMOVAL OF NECK WRINKLES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15826 | REMOVAL OF BROW WRINKLES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | 1/31/2024 | Retire effective 01/31/2024 |
| 15828 | REMOVAL OF FACE WRINKLES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15829 | REMOVAL OF SKIN WRINKLES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15830 | EXC SKIN ABD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 15832 | EXCISE EXCESSIVE SKIN THIGH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15833 | EXCISE EXCESSIVE SKIN LEG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15834 | EXCISE EXCESSIVE SKIN HIP | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15835 | EXCISE EXCESSIVE SKIN BUTTCK | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15836 | EXCISE EXCESSIVE SKIN ARM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15837 | EXCISE EXCESS SKIN ARM/HAND | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15838 | EXCISE EXCESS SKIN FAT PAD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15839 | EXCISE EXCESS SKIN & TISSUE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15847 | EXC SKIN ABD ADD-ON | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15876 | SUCTION LIPECTOMY HEAD&NECK | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15877 | SUCTION LIPECTOMY TRUNK | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 15878 | SUCTION LIPECTOMY UPR EXTREM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15879 | SUCTION LIPECTOMY LWR EXTREM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 15999 | UNLISTED PX EXC PRESSURE ULC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 17106 | DESTRUCTION OF SKIN LESIONS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 17107 | DESTRUCTION OF SKIN LESIONS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 17108 | DESTRUCTION OF SKIN LESIONS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 17340 | CRYOTHERAPY OF SKIN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 17360 | SKIN PEEL THERAPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 17380 | HAIR REMOVAL BY ELECTROLYSIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 17999 | UNLISTD PX SKN MUC MEMB SUBQ | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 19105 | CRYOSURG ABLATE FA EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19300 | REMOVAL OF BREAST TISSUE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 19303 | MAST SIMPLE COMPLETE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19316 | SUSPENSION OF BREAST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 19318 | Breast Reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | 1/31/2024 | Retire effective 01/31/2024 |
| 19325 | BREAST AUGMENTATION W/IMPLT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19328 | RMVL INTACT BREAST IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19330 | RMVL RUPTURED BREAST IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19340 | INSJ BREAST IMPLT SM D MAST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19342 | INSJ/RPLCMT BRST IMPLT SEP D | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19350 | BREAST RECONSTRUCTION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19355 | CORRECT INVERTED NIPPLE(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19357 | TISS XPNDR PLMT BRST RCNSTJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 19370 | REVJ PERI-IMPLT CAPSULE BRST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19371 | PERI-IMPLT CAPSLC BRST COMPL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 19499 | UNLISTED PROCEDURE BREAST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 20527 | INJ DUPUYTREN CORD W/ENZYME | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 20560 | NDL INSJ W/O NJX 1 OR 2 MUSC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 20561 | NDL INSJ W/O NJX 3+ MUSC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 20983 | ABLATE BONE TUMOR(S) PERQ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 20985 | CPTR-ASST DIR MS PX | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 20999 | UNLISTED PX MUSCSKEL GENERAL | 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 Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21089 | UNLISTED MAXLFCL PROSTH PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 21120 | RECONSTRUCTION OF CHIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21121 | RECONSTRUCTION OF CHIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21122 | RECONSTRUCTION OF CHIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21123 | RECONSTRUCTION OF CHIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21125 | Augmentation Lower Jaw Bone | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21127 | Augmentation Lower Jaw Bone | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21145 | Lefort I-1 Piece W/ Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21146 | Lefort I-2 Piece W/ Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21147 | Lefort I-3/> Piece W/ Graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21150 | Lefort li Anterior Intrusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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| 21151 | Lefort Ii W/Bone Grafts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21154 | Lefort Iii W/O Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21155 | Lefort Iii W/ Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21159 | Lefort Iii W/Fhdw/O Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21160 | Lefort Iii W/Fhd W/ Lefort I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21188 | Reconstruction Of Midface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21206 | Reconstruct Upper Jaw Bone | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21208 | Augmentation Of Facial Bones | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 21209 | Reduction Of Facial Bones | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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| 21248 | RECONSTRUCTION OF JAW | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 21249 | RECONSTRUCTION OF JAW | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 21299 | UNLISTED CRANFCL&MAXLFCL PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 21499 | UNLISTED MUSCSKEL PX HEAD | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 21685 | Hyoid Myotomy & Suspension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 21899 | UNLISTED PX NECK/THORAX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 22505 | MANIPULATION OF SPINE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 22526 | IDET SINGLE LEVEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22527 | IDET 1 OR MORE LEVELS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22586 | ARTHRD PRE-SAC NTRBDY L5-S1 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22867 | INSJ STABLJ DEV W/DCMPRN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22868 | INSJ STABLJ DEV W/DCMPRN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22869 | INSJ STABLJ DEV W/O DCMPRN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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| 22870 | INSJ STABLJ DEV W/O DCMPRN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 22899 | UNLISTED PROCEDURE SPINE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 22999 | UNLISTED PX ABDOMEN MUSCSKEL | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 23929 | UNLISTED PROCEDURE SHOULDER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 24300 | MNPJ ELBOW UNDER ANES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 24999 | UNLISTED PX HUMERUS/ELBOW | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 25259 | MANIPULATE WRIST W/ANESTHES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 25999 | UNLISTED PX FOREARM/WRIST | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 26340 | MANIPULATE FINGER W/ANESTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 26341 | MANIPULAT PALM CORD POST INJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 26989 | UNLISTED PX HANDS/FINGERS | 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 Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 27299 | UNLISTED PX PELVIS/HIP JOINT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 27599 | UNLISTED PX FEMUR/KNEE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 27703 | RECONSTRUCTION ANKLE JOINT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 27860 | FIXATION OF ANKLE JOINT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 27899 | UNLISTED PX LEG/ANKLE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 28890 | HI ENRGY ESWT PLANTAR FASCIA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 28899 | UNLISTED PX FOOT/TOES | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 29440 | Addition Of Walker To Cast | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 29799 | UNLISTED PX CASTING/STRPG | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 29866 | AUTGRFT IMPLNT KNEE W/SCOPE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 29914 | HIP ARTHRO W/FEMOROPLASTY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 29915 | HIP ARTHRO ACETABULOPLASTY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 29916 | HIP ARTHRO W/LABRAL REPAIR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 29999 | UNLISTED PX ARTHROSCOPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 30468 | RPR NSL VLV COLLAPSE W/IMPLT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 30469 | RPR NSL VLV COLLAPSE W/RMDLG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 30999 | UNLISTED PROCEDURE NOSE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 31299 | UNLISTED PX ACCESSORY SINUS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 31599 | UNLISTED PROCEDURE LARYNX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 31899 | UNLISTED PX TRACHEA BRONCHI | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 32994 | ABLATE PULM TUMOR PERQ CRYBL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 32998 | ABLATE PULM TUMOR PERQ RF | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 32999 | UNLISTED PX LUNGS & PLEURA | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 33211 | INSERT CARD ELECTRODES DUAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33267 | EXCL LAA OPEN ANY METHOD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33268 | EXCL LAA OPN OTH PX ANY METH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33269 | EXCL LAA THRSCP ANY METHOD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33274 | TCAT INSJ/RPL PERM LDLS PM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33275 | Tcat Rmvl Perm Ldls Pm W/Img | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33285 | INSJ SUBQ CAR RHYTHM MNTR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33418 | REPAIR TCAT MITRAL VALVE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33419 | REPAIR TCAT MITRAL VALVE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 33542 | Removal Of Heart Lesion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 33999 | UNLISTED PX CARDIAC SURGERY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 36299 | UNLISTED PX VASCULAR NJX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 36465 | NJX NONCMPND SCLRSNT 1 VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36466 | NJX NONCMPND SCLRSNT MLT VN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36468 | NJX SCLRSNT SPIDER VEINS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36470 | NJX SCLRSNT 1 INCMPTNT VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36471 | NJX SCLRSNT MLT INCMPTNT VN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36473 | ENDOVENOUS MCHNCHEM 1ST VEIN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 36474 | ENDOVENOUS MCHNCHEM ADD-ON | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 36475 | ENDOVENOUS RF 1ST VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36476 | ENDOVENOUS RF VEIN ADD-ON | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 36478 | ENDOVENOUS LASER 1ST VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36479 | ENDOVENOUS LASER VEIN ADDON | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36482 | ENDOVEN THER CHEM ADHES 1ST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36483 | ENDOVEN THER CHEM ADHES SBSQ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 36516 | Apheresis Immunoads Slctv | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 36836 | PRQ AV FSTL CRTJ UXTR 1 ACS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 36837 | PRQ AV FSTL CRT UXTR SEP ACS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 36522 | PHOTOPHERESIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37215 | TRANSCATH STENT CCA W/EPS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37216 | TRANSCATH STENT CCA W/O EPS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37217 | STENT PLACEMT RETRO CAROTID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 37218 | STENT PLACEMT ANTE CAROTID | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37241 | VASC EMBOLIZE/OCCLUDE VENOUS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37242 | VASC EMBOLIZE/OCCLUDE ARTERY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37243 | VASC EMBOLIZE/OCCLUDE ORGAN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37244 | VASC EMBOLIZE/OCCLUDE BLEED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37501 | UNLISTED VASC ENDOSCOPY PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 37500 | ENDOSCOPY LIGATE PERF VEINS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37700 | REVISE LEG VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37718 | LIGATE/STRIP SHORT LEG VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37722 | LIGATE/STRIP LONG LEG VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37735 | REMOVAL OF LEG VEINS/LESION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 37760 | LIGATE LEG VEINS RADICAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37761 | LIGATE LEG VEINS OPEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37765 | STAB PHLEB VEINS XTR 10-20 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37766 | PHLEB VEINS - EXTREM 20+ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37780 | REVISION OF LEG VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 37799 | UNLISTED PX VASCULAR SURGERY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 38129 | UNLISTED LAPS PX SPLEEN | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 37785 | LIGATE/DIVIDE/EXCISE VEIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38204 | BL DONOR SEARCH MANAGEMENT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38206 | HARVEST AUTO STEM CELLS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 38205 | HARVEST ALLOGENEIC STEM CELL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 38207 | CRYOPRESERVE STEM CELLS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38208 | THAW PRESERVED STEM CELLS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38209 | WASH HARVEST STEM CELLS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38210 | T-CELL DEPLETION OF HARVEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38211 | TUMOR CELL DEplete OF HARVEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38212 | RBC DEPLETION OF HARVEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38213 | PLATELET DEplete OF HARVEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38214 | VOLUME DEplete OF HARVEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38230 | BONE MARROW HARVEST ALLOGEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 38215 | HARVEST STEM CELL CONCENTRATE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38232 | BONE MARROW HARVEST AUTOLOG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 38241 | TRANSPLT AUTOL HCT/DONOR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 38240 | TRANSPLT ALLO HCT/DONOR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38242 | TRANSPLT ALLO LYMPHOCYTES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38243 | TRANSPLJ HEMATOPOIETIC BOOST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 38589 | UNLISTED LAPS PX LYMPHTC SYS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 38999 | UNLISTD PX HEMIC/LYMPHTC SYS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 39499 | UNLISTED PX MEDIASTINUM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 39599 | UNLISTED PX DIAPHRAGM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 40799 | UNLISTED PROCEDURE LIPS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 40899 | UNLISTED PX VESTIBULE MOUTH | 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 41599 | UNLISTED PX TONGUE FLR MOUTH | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 41820 | Excision Gum Each Quadrant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41821 | Excision Of Gum Flap | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| 41822 | Excision Of Gum Lesion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41823 | Excision Of Gum Lesion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41828 | Excision Of Gum Lesion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41830 | Removal Of Gum Tissue | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41870 | Gum Graft | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41872 | Repair Gum | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41874 | Repair Tooth Socket | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 41899 | UNLISTED PX DENTALVLR STRUX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 42299 | UNLISTED PX PALATE UVULA | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 42699 | UNLISTED PX SALIVRY GLND/DUX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 42999 | UNLISTED PX PHRNX ADND/TNSL | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 43206 | ESOPH OPTICAL ENDOMICROSCOPY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 38308 | INCISION OF LYMPH CHANNELS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43252 | EGD OPTICAL ENDOMICROSCOPY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 43236 | UPPR GI SCOPE W/SUBMUC INJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43289 | UNLISTED LAPS PX ESOPH | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 43290 | EGD FLX TRNSORL DPLMNT BALO | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 43291 | EGD FLX TRNSORL RMLV BALO | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 43499 | UNLISTED PROCEDURE ESOPHAGUS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 43284 | LAPS ESOPHGL SPHNCTR AGMNTJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43632 | REMOVAL OF STOMACH PARTIAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2023 | - | - |
| 43633 | REMOVAL OF STOMACH PARTIAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43659 | UNLISTED LAPS PX STOMACH | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 43644 | LAP GASTRIC BYPASS/ROUX-EN-Y | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43645 | LAP GASTR BYPASS INCL SMLL I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43770 | LAP PLACE GASTR ADJ DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43771 | LAP REVISE GASTR ADJ DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43772 | LAP RMLV GASTR ADJ DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 43773 | LAP REPLACE GASTR ADJ DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43774 | LAP RMVL GASTR ADJ ALL PARTS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43775 | LAP SLEEVE GASTRECTOMY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43842 | V-BAND GASTROPLASTY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43843 | GASTROPLASTY W/O V-BAND | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43845 | GASTROPLASTY DUODENAL SWITCH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43846 | GASTRIC BYPASS FOR OBESITY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43847 | GASTRIC BYPASS INCL SMALL I | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43848 | REVISION GASTROPLASTY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43886 | REVISE GASTRIC PORT OPEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 43999 | UNLISTED PROCEDURE STOMACH | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 44238 | UNLISTED LAPS PX INTESTINE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 44799 | UNLISTED PX SMALL INTESTINE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 44899 | UNLISTED PX MECKEL'S DVRTCLM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 44979 | UNLISTED LAPS PX APPENDIX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 45399 | UNLISTED PROCEDURE COLON | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 45499 | LAPAROSCOPE PROC RECTUM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 45999 | UNLISTED PROCEDURE RECTUM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 46707 | REPAIR ANORECTAL FIST W/PLUG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 46999 | UNLISTED PROCEDURE ANUS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 43887 | REMOVE GASTRIC PORT OPEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 47379 | UNLISTED LAPS PX LIVER | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 43888 | CHANGE GASTRIC PORT OPEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 47370 | LAPARO ABLATE LIVER TUMOR RF | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 47399 | UNLISTED PROCEDURE LIVER | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 47579 | UNLISTED LAPS PX BILIARY TRC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 47999 | UNLISTED PX BILIARY TRACT | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 48999 | UNLISTED PROCEDURE PANCREAS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 49329 | UNLSTD LAPS PX ABD PERTM&OMN | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 49659 | UNLSTD LAPS PX HRNAP HRNRPHY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 49999 | UNLISTED PX ABD PERTM&OMN | 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 Recommended Clinical Review to avoid post-service review. | - | - | - |
| 47382 | PERCUT ABLATE LIVER RF | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 50549 | UNLISTED LAPS PX RENAL | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 50250 | CRYOABLATE RENAL MASS OPEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 50360 | TRANSPLANTATION OF KIDNEY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 50949 | UNLISTED LAPS PX URETER | 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 Recommended Clinical Review to avoid post-service review. | - | - | - |
| 51999 | UNLISTED LAPS PX BLADDER | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 50593 | PERC CRYO ABLATE RENAL TUM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 51715 | ENDOSCOPIC INJECTION/IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 52327 | CYSTOSCOPY INJECT MATERIAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 52441 | CYSTOURETHRO W/IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 53860 | TRANSURETHRAL RF TREATMENT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 53899 | UNLISTED PX URINARY SYSTEM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 52442 | CYSTOURETHRO W/ADDL IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 53855 | INSERT PROST URETHRAL STENT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54125 | REMOVAL OF PENIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54200 | TREATMENT OF PENIS LESION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54205 | TREATMENT OF PENIS LESION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 54235 | Penile Injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54400 | INSERT SEMI-RIGID PROSTHESIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54401 | INSERT SELF-CONTD PROSTHESIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 54699 | UNLISTED LAPS PX TESTIS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 55559 | UNLSTD LAPS PX SPRMATIC CORD | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 54405 | INSERT MULTI-COMP PENIS PROS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 55899 | UNLISTED PX MALE GENITAL SYS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 54660 | REVISION OF TESTIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 55880 | ABLTJ MAL PRST8 TISS HIFU | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 55970 | SEX TRANSFORMATION M TO F | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 55980 | SEX TRANSFORMATION F TO M | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 56805 | REPAIR CLITORIS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 56810 | REPAIR OF PERINEUM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 57291 | CONSTRUCTION OF VAGINA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 57292 | CONSTRUCT VAGINA WITH GRAFT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 58578 | UNLISTED LAPS PX UTERUS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 58579 | UNLISTED HYSTSC PX UTERUS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 58679 | UNLISTED LAPS PX OVIDCT OVRY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 58999 | UNLISTED PX FML GENITAL SYS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 57335 | REPAIR VAGINA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 59897 | UNLISTED FETAL INVAS PX W/US | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 59898 | UNLSTD LAPS PX MAT CARE&DLVR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 59899 | UNLISTED PX MAT CARE&DLVR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 60659 | UNLISTED LAPS PX ENDOC SYS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 60699 | UNLISTED PX ENDOCRINE SYSTEM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 61630 | INTRACRANIAL ANGIOPLASTY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 57426 | REVISE PROSTH VAG GRAFT LAP | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 59074 | FETAL FLUID DRAINAGE W/US | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 61635 | INTRACRAN ANGIOPLSTY W/STENT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 62263 | EPIDURAL LYSIS MULT SESSIONS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 62264 | EPIDURAL LYSIS ON SINGLE DAY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 62287 | DCMPRN PX PERQ 1/MLT LUMBAR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 64582 | OPN MPLTJ HPGLSL NSTM ARY PG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 64628 | TRML DSTRJ IOS BVN 1ST 2 L/S | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 64629 | TRML DSTRJ IOS BVN EA ADDL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 61650 | Evasc Prlng Admn Rx Agnt 1St | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 64999 | UNLISTED PX NERVOUS SYSTEM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 65760 | REVISION OF CORNEA | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 61651 | Evasc Prlng Admn Rx Agnt Add | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 64640 | INJECTION TREATMENT OF NERVE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 65770 | REVISE CORNEA WITH IMPLANT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 65785 | IMPLTJ NTRSTRML CRNL RNG SEG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66174 | TRLUML DIL AQ O/F CAN W/O ST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66175 | TRLUML DIL AQ O/F CAN W/ST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66179 | AQUEOUS SHUNT EYE W/O GRAFT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66180 | AQUEOUS SHUNT EYE W/GRAFT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 66183 | INSERT ANT DRAINAGE DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66999 | UNLISTED PX ANT SEGMENT EYE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 67299 | UNLISTED PX POSTERIOR SEGMNT | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 67399 | UNLISTED PX EXTRAOCULAR MUSC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 67599 | UNLISTED PROCEDURE ORBIT | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 67900 | REPAIR BROW DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 66989 | XCPSL CTRC RMVL CPLX INSJ 1+ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 66991 | XCAPSL CTRC RMVL INSJ 1+ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 67901 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 67902 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 67903 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 67904 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 67999 | UNLISTED PROCEDURE EYELIDS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 68399 | UNLISTED PX CONJUNCTIVA | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 68899 | UNLISTED PX LACRIMAL SYSTEM | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 67906 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 67908 | REPAIR EYELID DEFECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69399 | UNLISTED PX EXTERNAL EAR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 69090 | PIERCE EARLOBES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69300 | REVISE EXTERNAL EAR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69714 | Implant Temple Bone W/Stimul | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 69705 | NPS SURG DILAT EUST TUBE UNI | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69717 | Temple Bone Implant Revision | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 69706 | NPS SURG DILAT EUST TUBE BI | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 69716 | IMPL OI IMPLT SK TC ESP<100 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69719 | RPLCM OI IMPLT SK TC ESP<100 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 69799 | UNLISTED PX MIDDLE EAR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 69930 | Implant Cochlear Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 69949 | UNLISTED PX INNER EAR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 69979 | UNLISTED PX TEMPORAL BONE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 76496 | UNLISTED FLUOROSCOPIC PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 76497 | UNLISTED CT PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 76498 | UNLISTED MR PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 76499 | UNLISTED DX RADIOGRAPHIC PX | 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 | UNLISTED PX THER RAD TX PLNG | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 77399 | UNLISTED PX MED RADJ PHYSICS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 77499 | UNLISTED PX THER RAD TX MGMT | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 77799 | UNLISTED PX CLIN BRACHYTX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78099 | UNLISTED ENDOCRINE PX DX NUC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78199 | UNLSTD HEMATOP RET/ENDO LYMP | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78299 | UNLISTED GI PX DX NUC MED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78399 | UNLISTED MUSCSKEL PX DX NUC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78499 | UNLISTED CV PX DX NUC MED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78599 | UNLISTED RESP PX DX NUC MED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78699 | UNLISTED NRVS SYS PX DX NUC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78799 | UNLISTED GU PX DX NUC MED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 78999 | UNLISTED MISC PX DX NUC MED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 79999 | RP THERAPY UNLISTED PX | 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 contract/clinical review. | - | - | - |
| 81099 | UNLISTED URINALYSIS PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 81479 | UNLISTED MOLECULAR PATHOLOGY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 81599 | UNLISTED MAAA | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| 82523 | COLLAGEN CROSSLINKS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 69728 | RMV NTR OI IMP SK TC>=100 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | – | – |
| 83695 | ASSAY OF LIPOPROTEIN(A) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83698 | ASSAY LIPOPROTEIN PLA2 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83701 | LIPOPROTEIN BLD HR FRACTION | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83704 | LIPOPROTEIN BLD QUAN PART | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83722 | LIPOPRTN DIR MEAS SD LDL CHL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83937 | ASSAY OF OSTEOCALCIN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 83987 | EXHALED BREATH CONDENSATE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 84112 | EVAL AMNIOTIC FLUID PROTEIN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 84431 | THROMBOXANE URINE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|----------|---|---|
| 84999 | UNLISTED CHEMISTRY PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 85999 | UNLISTED HEMATOLOGY&COAGJ PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 86001 | ALLERGEN SPECIFIC IGG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 86328 | IA NFCT AB SARSCOV2 COVID19 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |
| 86343 | LEUKOCYTE HISTAMINE RELEASE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 69730 | RPLC OI IMPLT SK TC ESP>=100 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | - | - |
| 83006 | Growth Stimulation Gene 2 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 86408 | NEUTRLZG ANTB SARSCOV2 SCR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |
| 86409 | NEUTRLZG ANTB SARSCOV2 TITER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |
| 86413 | SARS-COV-2 ANTB QUANTITATIVE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |
| 86486 | SKIN TEST UNLISTED ANTIGN EA | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 86769 | SARS-COV-2 COVID-19 ANTIBODY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |

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|-------|-----------------------------|---|---|---|---|
| 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. | - | - | - |
| 86352 | Cell Function Assay W/Stim | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 86999 | UNLISTED TRANSFUSION MED PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 86353 | LYMPHOCYTE TRANSFORMATION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 86950 | Leukocyte Transfusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 87505 | NFCT AGENT DETECTION GI | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 87797 | DETECT AGENT NOS DNA DIR | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 87798 | DETECT AGENT NOS DNA AMP | Unlisted: Procedure/service not specifically defined or classified, maybe subject to 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 | UNLISTED MICROBIOLOGY PX | 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 review. | - | - | - |
| 88005 | AUTOPSY (NECROPSY) GROSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| 88007 | AUTOPSY (NECROPSY) GROSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88012 | AUTOPSY (NECROPSY) GROSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88014 | AUTOPSY (NECROPSY) GROSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88016 | AUTOPSY (NECROPSY) GROSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88020 | AUTOPSY (NECROPSY) COMPLETE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88025 | AUTOPSY (NECROPSY) COMPLETE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88027 | AUTOPSY (NECROPSY) COMPLETE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88028 | AUTOPSY (NECROPSY) COMPLETE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88029 | AUTOPSY (NECROPSY) COMPLETE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88036 | LIMITED AUTOPSY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88037 | LIMITED AUTOPSY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88040 | FORENSIC AUTOPSY (NECROPSY) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88045 | CORONERS AUTOPSY (NECROPSY) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 88099 | UNLISTED NECROPSY (AUTOPSY) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 88199 | UNLISTED CYTOPATHOLOGY PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 88299 | UNLISTED CYTOGENETIC STUDY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 88375 | OPTICAL ENDOMICROSCOPY INTERP | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 88399 | UNLISTED SURGICAL PATH PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 88749 | UNLISTED IN VIVO LAB SERVICE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 89240 | UNLISTED MISC PATH TEST | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 89258 | CRYOPRESERVATION EMBRYO(S) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 87506 | IADNA-DNA/RNA PROBE TQ 6-11 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 87507 | IADNA-DNA/RNA PROBE TQ 12-25 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89259 | CRYOPRESERVATION SPERM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89335 | CRYOPRESERVE TESTICULAR TISS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89337 | CRYOPRESERVATION OOCYTE(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89342 | STORAGE/YEAR EMBRYO(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89346 | STORAGE/YEAR OOCYTE(S) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 89398 | UNLISTED REPROD MED LAB PROC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 90378 | RSV MAB IM 50MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| 90399 | UNLISTED IMMUNE GLOBULIN | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 90584 | Dengue Vacc Quad 2 Dose Subq | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 90689 | Vacc liv4 No Prsrv 0.25MI Im | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 90749 | UNLISTED VACCINE/TOXOID | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 89343 | STORAGE/YEAR SPERM/SEMEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 89344 | STORAGE/YEAR REPROD TISSUE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90867 | TCRANIAL MAGN STIM TX PLAN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90868 | TCRANIAL MAGN STIM TX DELI | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90869 | TCRAN MAGN STIM REDETERMINE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90870 | ELECTROCONVULSIVE THERAPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90880 | HYPNOTHERAPY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 90885 | PSY EVALUATION OF RECORDS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 90889 | PREPARATION OF REPORT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 90899 | UNLISTED PSYC SVC/THERAPY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 90875 | PSYCHOPHYSIOLOGICAL THERAPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 90876 | PSYCHOPHYSIOLOGICAL THERAPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90901 | BIOFEEDBACK TRAIN ANY METH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90999 | UNLISTED DIALYSIS PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 90912 | BFB TRAINING 1ST 15 MIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 90913 | BFB TRAINING EA ADDL 15 MIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 91034 | Gastroesophageal Reflux Test | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 91035 | G-Esoph Reflx Tst W/Electrod | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 91065 | BREATH HYDROGEN/METHANE TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91037 | Esoph Imped Function Test | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 91111 | GI TRC IMG INTRAL ESOPHAGUS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91112 | GI WIRELESS CAPSULE MEASURE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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| 91113 | GI TRC IMG INTRAL COLON I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 91038 | Esoph Imped Funct Test > 1Hr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 91132 | ELECTROGASTROGRAPHY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91133 | ELECTROGASTROGRAPHY W/TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91299 | UNLISTED DX GI PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 92015 | Determine Refractive State | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 92065 | ORTHOP TRAING PFRMD PHYS/QHP | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 92132 | CMPTR OPHTH DX IMG ANT SEGMT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 92145 | CORNEAL HYSTERESIS DETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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 | UNLISTED OPH SVC/PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| 92512 | NASAL FUNCTION STUDIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 92517 | VEMP TEST I&R CERVICAL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 92518 | VEMP TEST I&R OCULAR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 92519 | VEMP TST I&R CERVICAL&OCULAR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91110 | GI TRC IMG INTRAL ESOPH-ILE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 91117 | Colon Motility 6 Hr Study | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 92700 | UNLISTED ORL SERVICE/PX | 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 92546 | Sinusoidal Rotational Test | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 92640 | Aud Brainstem Implt Programg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 93228 | REMOTE 30 DAY ECG REV/REPORT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 93702 | BIS XTRACELL FLUID ANALYSIS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 93740 | TEMPERATURE GRADIENT STUDIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 93229 | REMOTE 30 DAY ECG TECH SUPP | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 93660 | TILT TABLE EVALUATION | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 93799 | UNLISTED CV SVC/PROCEDURE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 93998 | UNLISTD NONINVAS VASC DX STD | 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 94015 | PATIENT RECORDED SPIROMETRY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 94016 | REVIEW PATIENT SPIROMETRY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 94452 | HAST W/REPORT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 94453 | HAST W/OXYGEN TITRATE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| 94799 | UNLISTED PULMONARY SVC/PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 95060 | EYE ALLERGY TESTS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 95065 | NOSE ALLERGY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 95199 | UNLISTED ALL/IMMLG SVC/PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 93797 | Cardiac Rehab | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 93798 | Cardiac Rehab/Monitor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95700 | Eeg Cont Rec W/Vid Eeg Tech | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95705 | Eeg W/O Vid 2-12 Hr Unmnr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95706 | Eeg Wo Vid 2-12Hr Intmt Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95707 | Eeg W/O Vid 2-12Hr Cont Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95708 | Eeg Wo Vid Ea 12-26Hr Unmnr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95709 | Eeg W/O Vid Ea 12-26Hr Intmt | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 95710 | Eeg W/O Vid Ea 12-26Hr Cont | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95711 | Veeg 2-12 Hr Unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95712 | Veeg 2-12 Hr Intmt Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95713 | Veeg 2-12 Hr Cont Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95714 | Veeg Ea 12-26 Hr Unmntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95715 | Veeg Ea 12-26Hr Intmt Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95716 | Veeg Ea 12-26Hr Cont Mntr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95717 | Eeg Phys/Qhp 2-12 Hr W/O Vid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95718 | Eeg Phys/Qhp 2-12 Hr W/Veeg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95719 | Eeg Phys/Qhp Ea Incr W/O Vid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95720 | Eeg Phy/Qhp Ea Incr W/Veeg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| 95721 | Eeg Phy/Qhp>36<60 Hr W/O Vid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95722 | Eeg Phy/Qhp>36<60 Hr W/Veeg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95723 | Eeg Phy/Qhp>60<84 Hr W/O Vid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95724 | Eeg Phy/Qhp>60<84 Hr W/Veeg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95725 | Eeg Phy/Qhp>84 Hr W/O Vid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95905 | MOTOR &/ SENS NRVE CNDJ TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 95919 | QUAN PULMTRY PHY/QHP UNI/BI | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 95726 | Eeg Phy/Qhp>84 Hr W/Veeg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95803 | ACTIGRAPHY TESTING | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95954 | Eeg Monitoring/Giving Drugs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95957 | Eeg Digital Analysis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| 95965 | MEG SPONTANEOUS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95999 | UNLISTED NEUROLOGICAL DX PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 95966 | MEG EVOKED SINGLE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 95967 | MEG EVOKED EACH ADDL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96000 | MOTION ANALYSIS VIDEO/3D | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96001 | MOTION TEST W/FT PRESS MEAS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96002 | DYNAMIC SURFACE EMG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96379 | UNL THER/PROP/DIAG INJ/INF | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 96549 | UNLISTED CHEMOTHERAPY PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 96003 | DYNAMIC FINE WIRE EMG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96004 | PHYS REVIEW OF MOTION TESTS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96912 | PHOTOCHEMOTHERAPY WITH UV-A | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 96913 | PHOTOCHEMOTHERAPY UV-A OR B | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96922 | Laser Tx Skin >500 Sq Cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96931 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96932 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96933 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96934 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96999 | UNLISTED SPEC DERM SVC/PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 97039 | UNLISTED MODALITY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 97139 | UNLISTED THERAPEUTIC PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| 97169 | Athletic Trn Eval Low Cmplx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 97170 | Athletic Trn Eval Mod Cmplx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 97171 | Athletic Trn Eval High Cmplx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 97172 | Athletic Trn Re-Eval Plan Cr | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 96935 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 96936 | Rcm Celulr Subcelulr Img Skn | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 97610 | LOW FREQUENCY NON-THERMAL US | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 97799 | UNLISTED PHYSCL MED/REHAB PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99024 | Postop Follow-Up Visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99026 | IN-HOSPITAL ON CALL SERVICE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99027 | OUT-OF-HOSP ON CALL SERVICE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99050 | MEDICAL SERVICES AFTER HRS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99056 | MED SERVICE OUT OF OFFICE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99058 | OFFICE EMERGENCY CARE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99070 | SPECIAL SUPPLIES PHYS/QHP | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99071 | PATIENT EDUCATION MATERIALS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99075 | MEDICAL TESTIMONY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99078 | GROUP HEALTH EDUCATION | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| 99080 | SPECIAL REPORTS OR FORMS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99082 | UNUSUAL PHYSICIAN TRAVEL | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99199 | UNLISTED SPECIAL SVC PX/RPRT | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99360 | PHYSICIAN STANDBY SERVICES | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99429 | UNLISTED PREVENTIVE SERVICE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 99446 | Ntrprof Ph1/Ntrnet/Ehr 5-10 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99447 | Ntrprof Ph1/Ntrnet/Ehr 11-20 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99448 | Ntrprof Ph1/Ntrnet/Ehr 21-30 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99449 | Ntrprof Ph1/Ntrnet/Ehr 31/> | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99450 | BASIC LIFE DISABILITY EXAM | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99451 | Ntrprof Ph1/Ntrnet/Ehr 5/> | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 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 review. | - | - | - |
| 99456 | DISABILITY EXAMINATION | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99457 | Rem Physiol Mntr 1St 20 Min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 99491 | Chrc 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 contract/clinical review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 99600 | UNLISTED HOME VISIT SVC/PX | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| 0052U | LPOPRTN BLD W/5 MAJ CLASSES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0054T | BONE SRGRY CMPTR FLUOR IMAGE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0055T | BONE SRGRY CMPTR CT/MRI IMAG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0063U | NEURO AUTISM 32 AMINES ALG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 97533 | Sensory Integration | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 97537 | Community/Work Reintegration | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0084U | Rbc Dna Gnotyp 10 Bld Groups | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0086U | Nfct Ds Bact&Fng Org Id 6+ | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0091U | Onc Clrct Scr Whl Bld Alg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0092U | Onc Lng 3 Prtn Bmrk Plsm Alg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0093U | Rx Mntr 65 Com Drugs Urine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0095U | Inflm Ee Elisa Alys Alg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0096U | Hpv Hi Risk Types Male Urine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 0100T | PROSTH RETINA RECEIVE&GEN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0101T | ESW MUSCSKEL SYS NOS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0102T | ESW PHY ANES LAT HMRL EPCNDL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0105U | Neph Ckd Mult Eclia Tum Nec | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0106T | TOUCH QUANT SENSORY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0106U | GSTR EMPTG 7 TIMED BRTH SPEC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0107T | VIBRATE QUANT SENSORY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0107U | C Diff Tox Ag Detcj la Stool | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0108T | COOL QUANT SENSORY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0108U | Gi Barrett Esoph 9 Prtn Bmrk | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0109T | HEAT QUANT SENSORY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0109U | Id Aspergillus Dna 4 Species | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0110T | NOS QUANT SENSORY TEST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0110U | Rx Mntr 1+Oral Onc Rx&Sbsts | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 0112U | Iadi 16S&18S Rrna Genes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0115U | Respir Iadna 18 Viral&2 Bact | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0116U | Rx Mntr Nzm Ia 35+Oral Flu | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0117U | Pain Mgmt 11 Endogenous Anal | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0119U | Crđ Ceramides Liq Chrom Plsm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0121U | Sc Dis Vcam-1 Whole Blood | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0122U | Sc Dis P-Selectin Whl Blood | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0123U | Mchnl Fragility Rbc Prflg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0140U | Nfct Ds Fungi Dna 15 Trgt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0141U | Nfct Ds Bact&Fng Gram Pos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0142U | Nfct Ds Bact&Fng Gram Neg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0152U | Nfct Ds Dna Untrgt Ngnrj Seq | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0198T | OCULAR BLOOD FLOW MEASURE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0202T | POST VERT ARTHRPLST 1 LUMBAR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0207T | CLEAR EYELID GLAND W/HEAT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0219T | PLMT POST FACET IMPLT CERV | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0220T | PLMT POST FACET IMPLT THOR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| 0221T | PLMT POST FACET IMPLT LUMB | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0222T | PLMT POST FACET IMPLT ADDL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0224U | ANTIBODY SARS-COV-2 TITER(S) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| 0226U | SVNT SARSCOV2 ELISA PLSM SRM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| 0232T | NJX PLATELET PLASMA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0075T | PERQ STENT/CHEST VERT ART | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0263T | IM B1 MRW CEL THER CMPL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0264T | IM B1 MRW CEL THER XCL HRVST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0076T | S&I STENT/CHEST VERT ART | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0253T | INSERT AQUEOUS DRAIN DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |

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|-------|------------------------------|--|---|---|---|
| 0266T | IMPLT/RPL CRTD SNS DEV TOTAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0267T | IMPLT/RPL CRTD SNS DEV LEAD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0268T | IMPLT/RPL CRTD SNS DEV GEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0269T | REV/REML CRTD SNS DEV TOTAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0270T | REV/REML CRTD SNS DEV LEAD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0271T | REV/REML CRTD SNS DEV GEN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0274T | PERQ LAMOT/LAM CRV/THRC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0275T | PERQ LAMOT/LAM LUMBAR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0278T | TEMPR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0272T | INTERROGATE CRTD SNS DEV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| 0335T | INSJ SINUS TARSI IMPLANT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0338T | TRNSCTH RENAL SYMP DENRV UNL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0339T | TRNSCTH RENAL SYMP DENRV BIL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0273T | INTERROGATE CRTD SNS W/PGRMG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0347T | INS BONE DEVICE FOR RSA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0348T | RSA SPINE EXAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0349T | RSA UPPER EXTR EXAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0350T | RSA LOWER EXTR EXAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0331T | HEART SYMP IMAGE PLNR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0345T | TRANSCATH MTRAL VLVE REPAIR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0358T | BIA WHOLE BODY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| 0378T | VISUAL FIELD ASSMNT REV/RPRT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0379T | VIS FIELD ASSMNT TECH SUPPT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0397T | ERCP W/OPTICAL ENDOMICROSCPY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0352T | OCT BRST/NODE I&R PER SPEC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0424T | INSJ/RPLC NSTIM APNEA COMPL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0425T | INSJ/RPLC NSTIM APNEA SEN LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0426T | INSJ/RPLC NSTIM APNEA STM LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0427T | INSJ/RPLC NSTIM APNEA PLS GN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0428T | RMVL NSTIM APNEA PLS GEN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0429T | RMVL NSTIM APNEA SEN LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0430T | RMVL NSTIM APNEA STIMJ LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| 0431T | RMVL/RPLC NSTIM APNEA PLS GN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0432T | REPOS NSTIM APNEA STIMJ LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0433T | REPOS NSTIM APNEA SENSING LD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0434T | INTERRO EVAL NPGS APNEA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0435T | PRGRMG EVAL NPGS APNEA 1 SES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0436T | PRGRMG EVAL NPGS APNEA STUDY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0354T | OCT BREAST SURG CAVITY I&R | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0398T | MRFUS STRTCTC LES ABLTJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0464T | VISUAL EP TEST FOR GLAUCOMA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0449T | INSJ AQUEOUS DRAIN DEV 1ST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0472T | PRGRMG IO RTA ELTRD RA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| 0473T | REPRGRMG IO RTA ELTRD RA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0450T | INSJ AQUEOUS DRAIN DEV EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0465T | SUPCHRD L NJX RX W/O SUPPLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0474T | INSJ AQUEOUS DRG DEV IO RSVR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0479T | FXJL ABL LSR 1ST 100 SQ CM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0480T | FXJL ABL LSR EA ADDL 100SQCM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0485T | OCT MID EAR I&R UNILATERAL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0486T | OCT MID EAR I&R BILATERAL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0499T | CYSTO F/URTL STRIX/STENOSIS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0507T | NEAR IFR 2IMG MIBMN GLND I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0508T | PLS ECHO US B1 DNS MEAS TIB | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| 0509T | PATTERN ERG W/I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0511T | RMVL&RINSJ SINUS TARSI IMPLT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0512T | ESW INTEG WND HLG 1ST WND | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0513T | ESW INTEG WND HLG EA ADDL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0483T | TMVI PERCUTANEOUS APPROACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0533T | CONT REC MVMT DO 6-10 DAYS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0534T | CONT REC MVMT DO SETUP&TRAIN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0535T | CONT REC MVMT DO REPRT CNFIG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0536T | CONT REC MVMT DO DL W/I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0484T | TMVI TRANSTHORACIC EXPOSURE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0563T | EVAC MEIBOMIAN GLND HEAT BI | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|-----------|---|---|
| 0565T | AUTOL CELL IMPLT ADPS HRVG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0566T | AUTOL CELL IMPLT ADPS NJX | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0524T | EV CATH DIR CHEM ABLTJ W/IMG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0537T | BLD DRV T LYMPHCYT CAR-T CLL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | - | - |
| 0538T | BLD DRV T LYMPHCYT PREP TRNS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | - | - |
| 0539T | RECEIPT&PREP CAR-T CLL ADMIN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | - | - |
| 0602T | TRANSDERMAL GFR MEASUREMENTS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0603T | TRANSDERMAL GFR MONITORING | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0615T | EYE MVMT ALYS W/O CALBRJ I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0620T | EVASC VEN ARTLZ TIBL/PRNL VN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0621T | TRABECULOSTOMY INTERNO LASER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|--|-----------|---|---|
| 0622T | TRABECULOSTOMY INT LSR W/SCP | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0623T | AUTO QUANTIFICATION C PLAQUE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0624T | AUTO QUAN C PLAQ DATA PREP | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0625T | AUTO QUAN C PLAQ CPTR ALYS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0626T | AUTO QUAN C PLAQ I&R | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0627T | PERQ NJX ALGC FLUOR LMBR 1ST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0628T | PERQ NJX ALGC FLUOR LMBR EA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0629T | PERQ NJX ALGC CT LMBR 1ST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0630T | PERQ NJX ALGC CT LMBR EA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0631T | TC VIS LIT HYPERSPECTRAL IMG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0540T | CAR-T CLL ADMN AUTOLOGOUS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | – | – |

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|-------|------------------------------|--|----------|---|---|
| 0639T | WRLS SKN SNR ANISOTROPY MEAS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0640T | NCNTC NR IFR SPCTRSC WND | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0641T | NCNTC NR IFR SPCTRSC WND IMG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0544T | TCAT MV ANNULUS RCNSTJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0587T | PERQ IMPLTJ/RPLCMT ISDNS PTN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0588T | REVISION/REMOVAL ISDNS PTN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0589T | ELEC ALYS SMPL PRGRMG IINS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| 0651T | MAG CTRLD CAPSULE ENDOSCOPY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | – | – |
| 0656T | VRT BDY TETHERING ANT <7 SEG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 0657T | VRT BDY TETHERING ANT 8+ SEG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|----------|---|---|
| 0590T | ELEC ALYS CPLX PRGRMG IINS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0664T | DON HYSTERECTOMY OPEN CDVR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0665T | DON HYSTERECTOMY OPEN LIV | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0666T | DON HYSTERECTOMY LAPS LIV | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0667T | DON HYSTERECTOMY RCP UTER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0668T | BKBENCH PREP DON UTER ALGRFT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0669T | BKBENCH RCNSTJ DON UTER VEN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0670T | BKBENCH RCNSTJ DON UTER ARTL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0672T | NDOVAG CRYG RF REMDL TISS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 0743T | B1 STR & FX RSK VRT FX ASSMT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 0744T | INSJ BIOPROSTC VLV FEM VN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |

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|-------|------------------------------|--|-----------|---|---|
| 0632T | PERQ TCAT US ABLTJ NRV P-ART | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0643T | TCAT L VENTR RSTRJ DEV IMPLT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0645T | TCAT IMPLTJ C SINS RDCTJ DEV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0646T | TTVI/RPLCMT W/PRSTC VLV PERQ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0748T | NJX STM CL PRDCT ANL SFT TIS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0650T | PRGRMG DEV EVAL SCRMS REMOTE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0658T | Elec Impd Spectrsc 1+Skn Les | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 0766T | Tc Mag Stimj Pn 1St Tx 1Nrv | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | - | - |
| 0745T | CAR ABLT RAD ARR N-INVAS LOC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | - | - |
| 0767T | Tc Mag Stimj Pn 1St Tx Ea | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | - | - |
| 0746T | CAR ABLT RAD ARR CNV LOC MAP | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | - | - |

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|-------|------------------------------|--|-----------|---|---|
| 0768T | Tc Mag Stimj Pn Sbsq Tx 1Nrv | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | — | — |
| 0747T | CAR ABLT RAD ARRHYT DLVR RAD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | — | — |
| 0769T | Tc Mag Stimj Pn Sbsq Tx Ea | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | — | — |
| 0770T | VR TECHNOLOGY ASSIST THERAPY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | — | — |
| 0764T | ASSTV ALG ECG RSK ASMT CNCRT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | — | — |
| 0771T | VR PX DISSOC SVC SM PHY 1ST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | — | — |
| 0765T | ASSTV ALG ECG RSK ASMT PREV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | — | — |
| 0772T | VR PX DISSOC SVC SM PHY EA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | — | — |
| 0773T | VR PX DISSOC SVC OTH PHY 1ST | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | — | — |
| 0774T | VR PX DISSOC SVC OTH PHY EA | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | — | — |
| 0775T | ARTHRD SI JT PRQ IARTIC IMPL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | — | — |

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|-------|---|--|-----------|-----------|---|
| 0776T | OTHER INDCTJ NTRABRN HYPTRM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0777T | R-T PRS SENSING EDRL GDN SYS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0778T | SMMG CNCRNT APPL IMU SNR | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0779T | GI MYOELECTRICAL ACTV STUDY | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0781T | BRNCHSC RF DSTRJ PULM NRV BI | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0782T | BRNCHSC RF DSTRJ PLM NRV UNI | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| 0783T | TC AURICULR NEUROSTIMULATION | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| 0791T | Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | - | - |
| 0776T | OTHER INDCTJ NTRABRN HYPTRM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 8/31/2023 | - |
| 0793T | Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0795T | TCAT INS 2CHMBR LDLS PM CMPL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |

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|-------|----------------------------------|--|----------|---|---|
| 0796T | TCAT INS 2CHMBR LDLS PM RA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0797T | TCAT INS 2CHMBR LDLS PM RV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0798T | TCAT RMV 2CHMBR LDLS PM CMPL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0799T | TCAT RMVL 2CHMBR LDLS PM RA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0800T | TCAT RMVL 2CHMBR LDLS PM RV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0807T | PULM TISS VNTJ ALYS PREV CT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | - | - |
| 0808T | PULM TISS VNTJ ALYS W/CT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | - | - |
| 0801T | TCAT RMV&RPL 2CHMBR LDLS PM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 213AA | Proc/Treat/Equip/Ins/Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213BA | OTC Drugs Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213CA | Vision/Hear/Dental Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213EA | Assit Disabled/Misc Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213FA | Corr Eye Surgery Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213GA | Premiums Non- Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213HA | Copays Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|----------------------------------|--|----------|---|---|
| 213JA | Limited Purpose HCA Non- Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213KA | Preventative Care Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 213LA | Long Term Care Non-Covered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 9701A | NON-PRESCRIPTION DRUGS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 0802T | TCAT RMV&RPL2CHMB LDLS PM RA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0803T | TCAT RMV&RPL2CHMB LDLS PM RV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0804T | PRGRMG EVL LDLS PM 2CHMBR IP | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0805T | TCAT S&IVC PRSTC VL IMPL PRQ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0806T | TCAT S&IVC PRSTC VL IMPL OPN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| 0810T | SUBRTA NJX RX AGT W/VTRC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| A0999 | Unlisted ambulance service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A2001 | Innovamatrix ac per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A2002 | Mirragen adv wnd mat per sq | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|----------------------------|--|----------|---|---|
| A2004 | Xcellistem 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2005 | Microlyte matrix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2006 | Novosorb synpath per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2007 | Restrata per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2008 | Theragenesis per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2009 | Symphony per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2010 | Apis per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2011 | Supra sdrm per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2012 | Suprathel per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2013 | Innovamatrix fs per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| A2014 | Omeza collag per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | – | – |

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|-------|--|--|----------|---|---|
| A0426 | Als 1 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A2015 | Phoenix wnd mtrx per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | - | - |
| A0430 | Ambulance Service Conventional Air Services Transport One Way (Fixed Wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A2016 | Permeaderm b per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | - | - |
| A0431 | Rotary wing air transport | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A2017 | Permeaderm glove each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | - | - |
| A0435 | Fixed Wing Air Mileage Per Statute Mile | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A2018 | Permeaderm c per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | - | - |
| A0436 | Rotary wing air mileage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A2019 | Kerecis marigen shld sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| A0888 | Noncovered ambulance mileage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------------|--|----------|---|---|
| A2020 | Ac5 wound system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| A2021 | Neomatrix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| A4100 | Skin sub fda clrd as dev nos | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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 review. | - | - | - |
| A4520 | Incontinence garment anytype | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A4553 | Non-Disposable Underpads All Sizes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A4554 | Disposable underpads | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A4575 | Hyperbaric o2 chamber disps | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A4596 | Ces system monthly supp | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | - | - |
| A4639 | Infrared ht sys replcmnt pad | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A4641 | Radiopharm dx agent noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to 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. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| 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 review. | - | - | - |
| A4931 | Reusable oral thermometer | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A4932 | Reusable rectal thermometer | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A5507 | Modification diabetic shoe | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A6000 | Wound warming wound cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A6261 | Wound filler gel/paste /oz | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A6262 | Wound filler dry form / gram | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A6512 | Compres burn garment noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A6549 | G compression stocking | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A7049 | Epap nasal valve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| A9150 | Misc/exper non-prescript dru | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A9152 | Single vitamin nos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9153 | Multi-vitamin nos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9270 | Non-covered item or service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| A9273 | Hot/cold bottle/cap/col/wrap | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A9279 | Monitoring feature/deviceNOC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9280 | Alert device noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9282 | Wig any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A9285 | Inversion eversion cor devic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A9291 | Pres dig cog behav thera fda | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A9300 | Exercise equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| A9579 | Gad-base MR contrast NOS 1ml | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9597 | Pet dx for tumor id noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9598 | Pet dx for non-tumor id noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9698 | Non-rad contrast materialNOC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9699 | Radiopharm rx agent noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9900 | Supply/accessory/service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| A9999 | DME supply or accessory nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| B9998 | Enteral supp not otherwise c | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| A4555 | Ca tx e-stim electr/transduc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| A4600 | Sleeve inter limb comp dev | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1823 | Gen neuro trans sen/stim | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C1761 | Cath trans intra litho/coro | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1827 | Gen Neuro Imp Led Ex Cntr | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| C1764 | Event recorder cardiac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1776 | Joint device (implantable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1889 | Implant/insert device noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| C1783 | Ocular imp aqueous drain de | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C2698 | Brachytx stranded NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| C2699 | Brachytx non-stranded NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| C1818 | Integrated keratoprosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1825 | Gen neuro carot sinus baro | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C1826 | Gen neuro clo loop rechg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| C1833 | Cardiac monitor sys | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C2624 | Wireless pressure sensor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C5271 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| C5272 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| C9257 | Bevacizumab injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| C9354 | Veritas collagen matrix cm2 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9356 | TenoGlide tendon prot cm2 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|--|--|----------|---|---|
| C9358 | Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| C9360 | SurgiMend neonatal | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| C9363 | Integra Meshed Bil Wound Mat | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| C9364 | Porcine implant Permacol | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| C9399 | unclassified drugs or biologicals | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | – | – | – |
| C5273 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | – | – |
| C5274 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | – | – |
| C9757 | Spine/lumbar disk surgery | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| C5275 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | – | – |
| C5276 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | – | – |
| C5277 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | – | – |

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|-------|--|--|----------|---|---|
| C5278 | Low cost skin substitute app | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| C9768 | Endo us-guide hep porto grad | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9739 | Cystoscopy prostatic imp 1-3 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C9771 | Nsl/sins cryo post nasal tis | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9772 | Revasc lithotrip tibi/perone | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9773 | Revasc lithotr-stent tib/per | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9774 | Revasc lithotr-ather tib/per | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9775 | Revasc lith-sten-ath tib/per | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9777 | Esophag muc integ w/eso egd | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9898 | lnpnt stay radiolabeled item | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| C9899 | lnpt implant pros dev no cov | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| D0999 | unspecified diagnostic procedure by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|---|--|---|---|---|
| D1705 | Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5MI Im Dose 1 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| D1706 | Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5MI Im Dose 2 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| 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 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| D5899 | unspecified removable 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. | - | - | - |
| D7210 | extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| D7220 | removal of impacted tooth - soft tissue | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| D7230 | removal of impacted tooth - partially bony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| D7999 | unspecified oral surgery procedure by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| D8210 | removable appliance therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| D8220 | fixed appliance therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|---|--|---|---|---|
| D8999 | unspecified orthodontic procedure by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| D9999 | unspecified adjunctive procedure by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| C9740 | Cysto impl 4 or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0210 | Electric heat pad standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E0217 | Water circ heat pad w pump | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E0218 | Fluid circ cold pad w pump | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E0221 | Infrared heating pad system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E0231 | Wound warming device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E0232 | Warming card for NWT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| E0248 | HDtrans bench w/wo comm open | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E0273 | Bed board | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E0274 | Over-bed table | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| C9764 | Revasc intravasc lithotripsy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0315 | Bed accessory brd/tbl/supprt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| C9765 | Revasc intra lithotrip-stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 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. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| E0486 | Oral device/appliance cusfab | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| E0487 | Electronic spirometer | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| C9766 | Revasc intra lithotrip-ather | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0625 | Patient lift bathroom or toi | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| C9767 | Revasc lithotrip-stent-ather | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| C9769 | Cysto w/temp pros implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| C9770 | Vitrech/mech pars subret inj | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0183 | Press underlay alter w/pump | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0300 | Pediatric Crib Hospital Grade Fully Enclosed With Or Without Top Enclosure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0316 | Bed safety enclosure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0616 | Cardiac event recorder | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0635 | Patient Lift Electric With Seat Or Sling | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0637 | Combination Sit To Stand Frame/Table System Any Size Including Pediatric With Seat Lift Feature With Or Without Wheels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0638 | Standing Frame/Table System One Position (E.G. Upright Supine Or Prone Stander) Any Size Including Pediatric With Or Without Wheels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0641 | Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or Without Wheels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0642 | Standing Frame/Table System Mobile (Dynamic Stander) Any Size Including Pediatric | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| E0650 | Pneuma compresor non-segment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0651 | Pneum compresor segmental | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0652 | Pneum compres w/cal pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0655 | Pneumatic appliance half arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0656 | Segmental pneumatic trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0657 | Segmental pneumatic chest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0660 | Pneumatic appliance full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0665 | Pneumatic appliance full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0666 | Pneumatic appliance half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0675 | Pneumatic compression device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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| E0676 | Inter limb compress dev NOS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| E0667 | Seg pneumatic appl full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0668 | Seg pneumatic appl full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0669 | Seg pneumatic appli half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0670 | Seg pneum int legs/trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0740 | Non-implant pelv flr e-stim | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E0671 | Pressure pneum appl full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0672 | Pressure pneum appl full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0673 | Pressure pneum appl half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0762 | Trans elec jt stim dev sys | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|--|---|----------|---|
| E0764 | Functional neuromuscularstim | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0677 | Non pneum seq comp trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | 7/1/2023 | – |
| E0769 | Electric wound treatment dev | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0770 | Functional electric stim NOS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| E0830 | Ambulatory traction device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0840 | Tract frame attach headboard | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0849 | Cervical pneum trac equip | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0850 | Traction stand free standing | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0855 | Cervical traction equipment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0856 | Cervic collar w air bladders | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| E0860 | Tract equip cervical tract | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0890 | Traction frame attach pelvic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0936 | CPM device other than knee | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0942 | Cervical head harness/halter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0944 | Pelvic belt/harness/boot | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| E0691 | Uvl pnl 2 sq ft or less | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| E0692 | Uvl sys panel 4 ft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| E0693 | Uvl sys panel 6 ft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| E0694 | Uvl md cabinet sys 6 ft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| E0747 | Elec osteogen stim not spine | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| E0760 | Osteogen ultrasound stimltor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |

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| E0761 | Nontherm electromgntc device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0766 | Elec stim cancer treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0985 | W/c seat lift mechanism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E0986 | Man w/c push-rim powr system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1002 | Pwr seat tilt | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1003 | Pwr seat recline | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1004 | Pwr seat recline mech | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1229 | Pediatric wheelchair NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| E1005 | Pwr seat recline pwr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1239 | Ped power wheelchair NOS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| E1399 | Durable medical equipment mi | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| E1006 | Pwr seat combo w/o shear | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1632 | Wearable artificial kidney | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E1701 | Repl cushions for jaw motion | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E1702 | Repl measr scales jaw motion | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E1007 | Pwr seat combo w/shear | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1008 | Pwr seat combo pwr shear | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1009 | Add mech leg elevation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1010 | Add pwr leg elevation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1012 | Ctr mount pwr elev leg rest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| E1161 | Manual Adult Size Wheelchair Includes Tilt In Space | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1230 | Power operated vehicle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E1629 | Tablo for dialysis service | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2300 | Pwr seat elevation sys | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2301 | Pwr standing | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2310 | Electro connect btw control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2311 | Electro connect btw 2 sys | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2312 | Mini-prop remote joystick | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2313 | PWC harness expand control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2321 | Hand interface joystick | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2322 | Mult mech switches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| E2323 | Special joystick handle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2324 | Chin cup interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2325 | Sip and puff interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2326 | Breath tube kit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2327 | Head control interface mech | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2328 | Head/extremity control inter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2329 | Head control nonproportional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2330 | Head control proximity switc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2331 | Attendant control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2340 | W/c wdth 20-23 in seat frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2341 | W/c wdth 24-27 in seat frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| E2342 | W/c dpth 20-21 in seat frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2343 | W/c dpth 22-25 in seat frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2351 | Electronic SGD interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2373 | Hand/chin ctrl spec joystick | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2374 | Hand/chin ctrl std joystick | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2375 | Non-expandable controller | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2376 | Expandable controller repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2377 | Expandable controller initl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2599 | SGD accessory noc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| E2500 | SGD digitized pre-rec <=8min | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| E2502 | SGD prerec msg >8min <=20min | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G0235 | Pet imaging any site not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0255 | Current percep threshold tst | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0281 | Elec stim unattend for press | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| G0282 | Elect stim wound care not pd | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| G0329 | Electromagntic tx for ulcers | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E2504 | SGD prerec msg>20min <=40min | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| E2506 | SGD prerec msg > 40 min | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2508 | SGD spelling phys contact | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2510 | SGD w multi methods msg/accs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| E2511 | SGD sftwre prgrm for PC/PDA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G0428 | Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| E2512 | SGD accessory mounting sys | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G0460 | Autolog prp not diab ulcer | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| G0465 | Autolog prp diab wound ulcer | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| G2011 | Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| E2610 | Wheelchair Seat Cushion Powered | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G0176 | OPPS/PHP;activity therapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G8395 | LVEF>=40% doc normal or mild | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|-------------------------------|--|---|---|---|
| G8396 | LVEF not performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8397 | Dil macula/fundus exam/w doc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8399 | Pt w/dxa results document | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8400 | Pt w/dxa no results doc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8404 | Low extremity neur exam docum | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8405 | Low extremity neur not perfor | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8410 | Eval on foot documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8415 | Eval on foot not performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8416 | Pt inelig footwear evaluatio | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8417 | Calc bmi abv up param f/u | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8418 | Calc bmi blw low param f/u | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-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. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| G8427 | Docrev cur meds by elig clin | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8428 | Cur meds not document | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8430 | Doc med rsn no medrec | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8431 | Pos clin depres scrn f/u doc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8432 | Dep scr not doc rng | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8433 | Scr for dep not cpt doc rsn | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8450 | Beta-bloc rx pt w/abn lvef | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8451 | Pt w/abn lvef inelig b-bloc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8452 | Pt w/abn lvef b-bloc no rx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8465 | High risk recurrence pro ca | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8473 | ACE/ARB thxpy rx?d | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| G8474 | Ace/arb not rx'd; doc reas | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8475 | ACE/ARB thxpy not rx?d | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8476 | Bp sys <140 and dias <90 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8477 | Bp sys>=140 and/or dias >=90 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8478 | BP not performed/doc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8482 | Flu immunize order/admin | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8483 | Flu imm no admin doc rea | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G8484 | Flu immunize no admin | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9012 | Other Specified Case Mgmt | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| G9050 | Oncology work-up evaluation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9051 | Oncology tx decision-mgmt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9052 | Onc surveillance for disease | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9053 | Onc expectant management pt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9054 | Onc supervision palliative | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9055 | Onc visit unspecified NOS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 review. | - | - | - |
| G9059 | Onc prac mgmt pt opt alterna | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9060 | Onc prac mgmt dif pt comorb | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9061 | Onc prac cond noadd by guide | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|-------------------------------|--|---|---|---|
| G9062 | Onc prac guide differs nos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9063 | Onc dx nsclc stg1 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 review. | - | - | - |
| G9068 | Onc dx sclc/nsclc limited | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9069 | Onc dx sclc/nsclc ext at dx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9070 | Onc dx sclc/nsclc ext unknwn | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9071 | Onc dx brst stg1-2B HR nopro | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9072 | Onc dx brst stg1-2 noprogres | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9073 | Onc dx brst stg3-HR no pro | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9074 | Onc dx brst stg3-noprogress | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9075 | Onc dx brst metastatic/ recur | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9077 | Onc dx prostate T1no progres | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9078 | Onc dx prostate T2no progres | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9079 | Onc dx prostate T3b-T4noprog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9080 | Onc dx prostate w/rise PSA | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9083 | Onc dx prostate unknwn nos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9084 | Onc dx colon t1-3 n1-2 no pr | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9085 | Onc dx colon T4 N0 w/o prog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9086 | Onc dx colon T1-4 no dx prog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9087 | Onc dx colon metas evid dx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| G9088 | Onc dx colon metas noevid dx | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9089 | Onc dx colon extent unknown | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9090 | Onc dx rectal T1-2 no progr | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9091 | Onc dx rectal T3 N0 no prog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9092 | Onc dx rectal T1-3 N1-2noprg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9093 | Onc dx rectal T4 N M0 no prg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9094 | Onc dx rectal M1 w/mets prog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9095 | Onc dx rectal extent unknwn | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9096 | Onc dx esophag T1-T3 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 review. | - | - | - |
| G9101 | Onc dx gastric p R1-R2noprog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9102 | Onc dx gastric unresectable | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9103 | Onc dx gastric recurrent | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9104 | Onc dx gastric unknown NOS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9105 | Onc dx pancreatc p R0 res no | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9106 | Onc dx pancreatc p R1/R2 no | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9107 | Onc dx pancreatic unresectab | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9108 | Onc dx pancreatic unknwn NOS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9109 | Onc dx head/neck T1-T2no prg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9110 | Onc dx head/neck T3-4 noprog | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| G9111 | Onc dx head/neck M1 mets rec | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9112 | Onc dx head/neck ext unknown | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9113 | Onc dx ovarian stg1A-B no pr | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9114 | Onc dx ovarian stg1A-B or 2 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9115 | Onc dx ovarian stg3/4 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 review. | - | - | - |
| G9125 | Onc dx CML blast phase | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9126 | Onc dx CML remission | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9128 | Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Smoldering Stage I (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9129 | Onc dx mult myeloma stg2 hig | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9130 | Onc dx multi myeloma unknown | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9131 | Onc dx brst unknown NOS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9132 | Onc dx prostate mets no cast | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9133 | Onc dx prostate clinical met | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9134 | Onc NHLstg 1-2 no relap no | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9135 | Onc dx NHL stg 3-4 not relap | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9136 | Onc dx NHL trans to lg Bcell | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9137 | Onc dx NHL relapse/refractor | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9138 | Onc dx NHL stg unknown | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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| G9139 | Onc dx CML dx status unknown | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9140 | Frontier extended stay demo | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9147 | Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous by any means guided by the results of measurements for:respiratory quotient; and/or urine urea nitrogen (UUN); and/or arterial venous or capillary glucose; and/or potassium concentration | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| G9978 | Remote E/M New Pt 10Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9979 | Remote E/M New Pt 20Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9980 | Remote E/M New Pt 30 Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9981 | Remote E/M New Pt 45Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9982 | Remote E/M New Pt 60Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9983 | Remote E/M Est. Pt 10Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9984 | Remote E/M Est. Pt 15Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9985 | Remote E/M Est. Pt 25Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9986 | Remote E/M Est. Pt 40Mins | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| G9987 | Bpci Advanced In Home Visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| H0046 | Mental health service nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| H0047 | Alcohol/drug abuse svc nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J0129 | Abatacept injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0341 | Percutaneous islet celltrans | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| J0202 | Injection alemtuzumab | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0342 | Laparoscopy islet cell trans | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J0219 | Inj aval alfa-nqpt 4mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0220 | Alglucosidase alfa injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J0222 | Inj. patisiran 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0223 | Inj givosiran 0.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0224 | Inj. lumasiran 0.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0343 | Laparotomy islet cell transp | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J0256 | Alpha 1 proteinase inhibitor | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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| J0490 | INJECTION BELIMUMAB 10 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0491 | Inj anifrolumab-fnia 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0517 | Inj. benralizumab 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0565 | Inj bezlotoxumab 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0567 | Inj. cerliponase alfa 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0584 | Injection burosumab-twza 1m | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0586 | AbobotulinumtoxinA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0587 | Inj rimabotulinumtoxinB | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0588 | INJECTION INCOBOTULINUMTOXIN A 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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| J0717 | Certolizumab pegol inj 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0775 | Collagenase clost hist inj | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0791 | Inj crizanlizumab-tmca 5mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0881 | Darbepoetin alfa non-esrd | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1301 | Injection edaravone 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0422 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1303 | Inj. ravulizumab-cwvz 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1305 | Inj evinacumab-dgnb 5mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1306 | Injection inclisiran 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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| J1325 | Epoprostenol injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G0423 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G0429 | Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g. as a result of highly active antiretroviral therapy.) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| G2082 | Visit esketamine 56m or less | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1428 | Inj eteplirsen 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| G2083 | Visit esketamine > 56m | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1551 | Inj cutaquig 100 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1554 | Inj. asceniv | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1566 | Immune globulin powder | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1599 | Ivig non-lyophilized NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| J0172 | Inj aducanumab-avwa 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1729 | Inj hydroxyprogst capoat nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J1746 | Inj. ibalizumab-uiyk 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0218 | Inj olipudase alfa-rpcp 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| J1823 | Inj. inebilizumab-cdon 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J0225 | Inj vutrisiran 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1302 | Inj sutimlimab-jome 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J2182 | Injection mepolizumab 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J2278 | Ziconotide injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1411 | Inj hemgenix per tx dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023 | - | - |

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|-------|------------------------------|---|----------|---|---|
| J2356 | Inj tezepelumab-ekko 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1426 | Injection casimersen 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J2502 | Inj pasireotide long acting | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1427 | Inj. viltolarsen | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1429 | Inj golodirsen 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1632 | Inj. brexanolone 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1747 | Inj spesolimab-sbzo 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023 | - | - |
| J3032 | Inj. eptinezumab-jjmr 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3121 | Inj testostero enanthate 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3145 | Testosterone undecanoate 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| J3241 | Inj. teprotumumab-trbw 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3245 | Inj. tildrakizumab 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3285 | Treprostinil injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J1951 | Inj fensolvi 0.25 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J1954 | Leuprolide depot cipla 7.5mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | - | - |
| J3380 | Injection vedolizumab | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3398 | Inj luxturna 1 billion vec g | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3399 | Inj onase abepar-xioi treat | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3490 | Drugs unclassified injection | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| J2327 | Inj risankizumab-rzaa 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|--------------------------------------|---|---|---|---|
| J3570 | Laetrile amygdalin vit B17 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| J3590 | Unclassified biologics | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3591 | Esrd on dialysi drug/bio noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J2440 | Injection Papaverine Hcl Up To 60 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J7178 | Inj human fibrinogen con nos | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J7192 | Factor viii recombinant NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J7195 | Factor ix recombinant nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J7199 | Hemophilia clot factor noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J2777 | Inj faricimab-svoa 0.1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J2778 | Injection Ranibizumab 0.1 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J7599 | Immunosuppressive drug noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J7604 | Acetylcysteine comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7607 | Levalbuterol comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|--|---|---|---|
| J7609 | Albuterol comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7610 | Albuterol comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7615 | Levalbuterol comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7622 | Beclomethasone comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7624 | Betamethasone comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7627 | Budesonide comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7628 | Bitolterol mesylate comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7629 | Bitolterol mesylate comp unt | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7632 | Cromolyn sodium comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7634 | Budesonide comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7635 | Atropine comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|--------------------------|--|---|---|---|
| J7636 | Atropine comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7637 | Dexamethasone comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7638 | Dexamethasone comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7640 | Formoterol comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7641 | Flunisolide comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7642 | Glycopyrrolate comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7643 | Glycopyrrolate comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7645 | Ipratropium bromide comp | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7647 | Isoetharine comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7650 | Isoetharine comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| J7657 | Isoproterenol comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|-----------------------------|--|---|---|---|
| J7660 | Isoproterenol comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7667 | Metaproterenol comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7670 | Metaproterenol comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7676 | Pentamidine comp unit dose | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7680 | Terbutaline sulf comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7681 | Terbutaline sulf comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7683 | Triamcinolone comp con | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7684 | Triamcinolone comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| J7685 | Tobramycin comp unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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. | - | - | - |
| J7999 | Compounded drug noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|--|---|---|---|---|
| J8498 | Antiemetic rectal/supp NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| J8499 | 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. | - | - | - |
| J8999 | 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. | - | - | - |
| J2779 | Inj susvimo 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J9285 | Inj olaratumab 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| J9332 | Inj efgartigimod 2mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3299 | Inj xipere 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J9999 | Chemotherapy drug | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| J3520 | Edetate disodium per 150 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J7177 | Inj. fibryga 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J7309 | Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|--------------------------------|--|---|---|---|
| J7316 | Injection Ocriplasmin 0.125 Mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J7402 | Mometasone sinus sinuva | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| J9600 | Porfimer sodium injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0108 | W/c component-accessory NOS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0005 | Ultralightweight wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0010 | Stnd wt frame power whlchr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0011 | Stnd wt pwr whlchr w control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0012 | Ltwrt portbl power whlchr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0013 | Custom power whlchr base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0014 | Other power whlchr base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| K0053 | Elevate footrest articulate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0812 | Power operated vehicle NOC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0065 | Spoke protectors | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0455 | Pump uninterrupted infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0800 | POV group 1 std up to 300lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0801 | POV group 1 hd 301-450 lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0802 | POV group 1 vhd 451-600 lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0806 | POV group 2 std up to 300lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0807 | POV group 2 hd 301-450 lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0808 | POV group 2 vhd 451-600 lbs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| K0813 | PWC gp 1 std port seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0814 | PWC gp 1 std port cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0815 | PWC gp 1 std seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0816 | PWC gp 1 std cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0820 | PWC gp 2 std port seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0821 | PWC gp 2 std port cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0822 | PWC gp 2 std seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0823 | PWC gp 2 std cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0824 | PWC gp 2 hd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| K0825 | PWC gp 2 hd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0826 | PWC gp 2 vhd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0827 | PWC gp vhd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0828 | PWC gp 2 xtra hd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0829 | PWC gp 2 xtra hd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0830 | PWC gp2 std seat elevate s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0831 | PWC gp2 std seat elevate cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0835 | PWC gp2 std sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0836 | PWC gp2 std sing pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0837 | PWC gp 2 hd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0838 | PWC gp 2 hd sing pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| K0839 | PWC gp2 vhd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0840 | PWC gp2 xhd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0841 | PWC gp2 std mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0842 | PWC gp2 std mult pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0843 | PWC gp2 hd mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0848 | PWC gp 3 std seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0849 | PWC gp 3 std cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0850 | PWC gp 3 hd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0851 | PWC gp 3 hd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0852 | PWC gp 3 vhd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0853 | PWC gp 3 vhd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| K0854 | PWC gp 3 xhd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0855 | PWC gp 3 xhd cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0856 | PWC gp3 std sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0857 | PWC gp3 std sing pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0858 | PWC gp3 hd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0859 | PWC gp3 hd sing pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0860 | PWC gp3 vhd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0861 | PWC gp3 std mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0862 | PWC gp3 hd mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0863 | PWC gp3 vhd mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0864 | PWC gp3 xhd mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| K0868 | PWC gp 4 std seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0869 | PWC gp 4 std cap chair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0870 | PWC gp 4 hd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0871 | PWC gp 4 vhd seat/back | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0877 | PWC gp4 std sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0898 | Power wheelchair NOC | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0878 | PWC gp4 std sing pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K1002 | Ces system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| K1003 | Whirlpool Tub Walkin Portabl | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| K1004 | Lo freq us diathermy device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| K1009 | Speech volume modulation sys | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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|-------|------------------------------|---|---|---|---|
| K1018 | Ext up limb tremor stim wris | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| K1019 | Supp ext up limb tremor stim | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| K0879 | PWC gp4 hd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K1023 | Trans elec nerv periph nerv | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| K1027 | Oral dev without fix mech | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| K0880 | PWC gp4 vhd sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L0999 | Add to spinal orthosis NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L1499 | Spinal orthosis NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0884 | PWC gp4 std mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L2999 | Lower extremity orthosis NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L3040 | Ft arch suprt premold longit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| L3050 | Foot arch supp premold metat | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| L3060 | Foot arch supp longitud/meta | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| L3649 | Orthopedic shoe modifica NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L3999 | Upper limb orthosis NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0885 | PWC gp4 std mult pow opt cap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0886 | PWC gp4 hd mult pow s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L5999 | Lowr extremity prosthes NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| K0890 | PWC gp5 ped sing pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0891 | PWC gp5 ped mult pow opt s/b | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K0899 | Pow mobil dev no dmepdac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K1020 | Non-invasive vagus nerv stim | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K1024 | Non pneum comp control cal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| K1025 | Non pneum compress full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |

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|-------|---|---|----------|---|---|
| K1030 | Ext recharge bat replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| K1031 | Non pneu comp control w/o ca | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| K1032 | Non pneum seq comp full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| K1033 | Non pneum seq comp half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | - | - |
| L1844 | Ko w/adj jt rot cntrl molded | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L5857 | Elec knee-shin swing only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L5973 | Ank-foot sys dors-plant flex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6026 | Part hand myo exclu term dev | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6611 | Additional switch ext power | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6880 | ELECTRIC HAND SWITCH OR MYOELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTOR(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6920 | Wrist disarticul switch ctrl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| L6925 | Wrist disart myoelectronic c | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6930 | Below elbow switch control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6935 | Below elbow myoelectronic ct | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6940 | Elbow disarticulation switch | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6945 | Elbow disart myoelectronic c | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6950 | Above elbow switch control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6955 | Above elbow myoelectronic ct | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6960 | Shldr disartic switch contro | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6965 | Shldr disartic myoelectronic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6970 | Interscapular-thor switch ct | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L6975 | Interscap-thor myoelectronic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| L7499 | Upper extremity prosthes NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L8039 | Breast prosthesis NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L8048 | Unspec maxillofacial prosth | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L8499 | Unlisted misc prosthetic ser | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L7008 | Pediatric electric hand | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L8605 | Inj bulking agent anal canal | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| L7009 | Adult electric hook | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L8608 | Arg ii ext com/sup/acc misc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| L7040 | Prehensile actuator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L8614 | Cochlear Device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8615 | Coch Implant Headset Replace | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| L8616 | Coch Implant Microphone Repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8617 | Coch Implant Trans Coil Repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8618 | Coch Implant Tran Cable Repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8619 | Coch Imp Ext Proc/Contr Rplc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8621 | Repl Zinc Air Battery | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8622 | Repl Alkaline Battery | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8623 | Lith Ion Batt Cid Non-Earlvl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8624 | Lith Ion Batt Cid Ear Level | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8627 | Cid Ext Speech Process Repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |

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|-------|------------------------------|---|----------|---|---|
| L8628 | Cid Ext Controller Repl | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8629 | Cid Transmit Coil And Cable | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8690 | Aud Osseo Dev Int/Ext Comp | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8691 | Aoi Snd Proc Repl Excl Actua | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8693 | Aud Osseo Dev Abutment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| L8699 | Prosthetic implant NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L7045 | Pediatric electric hook | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L7170 | Electronic elbow hosmer swit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| M0075 | Cellular therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| M0240 | Casiri and imdev repeat | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |

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|-------|------------------------------|---|----------|---|---|
| M0241 | Casiri and imdev repeat hm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| M0243 | Casirivi and imdevi inj | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| M0244 | Casirivi and imdevi inj hm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| M0245 | bamlan and etesev infusion | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| M0246 | Bamlan and etesev infus home | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| L7180 | Electronic elbow sequential | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| P9020 | Plaelet rich plasma unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| P9099 | Blood component/product noc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | – | – | – |
| Q0240 | Casirivi and imdevi 600mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| Q0243 | casirivimab and imdevimab | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |
| Q0244 | Casirivi and imdevi 1200 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | – | – |

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|-------|-------------------------------|---|----------|---|---|
| Q0245 | bamlanivimab and etesevima | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | - | - |
| Q0507 | Misc sup/acc ext VAD | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q0508 | Misc sup/acc imp VAD | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q0509 | Mis sup/ac imp VAD nopay med | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q0510 | Dispens fee immunosuppressive | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| Q0511 | Sup fee antiem antica immuno | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| Q0512 | Px sup fee anti-can sub pres | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| L7181 | Electronic elbo simultaneous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L7185 | Electron elbow adolescent sw | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q2039 | Influenza virus vaccine nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q2041 | Axicabtagene ciloleucl car+ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2042 | Tisagenlecleucl car-pos t | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2050 | Doxorubicin inj 10mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2052 | Ivig demo services/supplies | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| Q2053 | Brexucabtagene car pos t | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2054 | Lisocabtagene mara car pos t | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2055 | Idecabtagene vicleucel car | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q2056 | Ciltacabtagene car-pos t | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q4050 | Cast supplies unlisted | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q4051 | Splint supplies misc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q4082 | Drug/bio NOC part B drug CAP | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q4100 | Skin substitute NOS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| L7186 | Electron elbow child switch | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L7190 | Elbow adolescent myoelectron | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| Q4103 | Oasis burn matrix | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4104 | Integra BMWD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| L7191 | Elbow child myoelectronic ct | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L7364 | Twelve volt battery utah/equ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L7366 | Battery chrgr 12 volt utah/e | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| L8604 | Dextranomer/hyaluronic acid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4110 | Primatrix | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4111 | Gammagraft | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4112 | Cymetra injectable | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4113 | Graftjacket xpress | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| L8606 | Synthetic implnt urinary 1ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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| Q4115 | Alloskin | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| L8612 | Aqueous shunt prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4117 | Hyalomatrix | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4118 | Matristem micromatrix | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4121 | Theraskin | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| L8701 | Ewh s/d uprt micro sensor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4123 | ALLOSKIN RT PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4124 | OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4125 | ARTHROFLEX PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4126 | Memoderm/derma/tranz/integup | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4127 | TALYMED PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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| L8702 | Ewhf s/d uprt micro sensor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4130 | STRATTICE TM PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| P2031 | Hair analysis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q2026 | Radiesse injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4134 | hMatrix | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4135 | Mediskin | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4136 | EZderm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4137 | Amnioexcel biodexcel 1sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4138 | Biodfence dryflex 1cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4139 | Amnio or biodmatrix inj 1cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4140 | Biodfence 1cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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| Q4141 | Alloskin ac 1 cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4142 | Xcm biologic tiss matrix 1cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4143 | Repriza 1cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4145 | Epifix inj 1mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4146 | Tensix 1cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4148 | Neox neox rt or clarix cord | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4149 | Excellagen 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q2028 | Inj sculptra 0.5mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4152 | Dermapure 1 square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|----------------------------|--|---|---|---|
| Q4153 | Dermavest plurivest sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4101 | Apligraf | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4155 | Neoxflo or clariflo 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4156 | Neox 100 or clarix 100 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4157 | Revitalon 1 square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4158 | Kerecis omega3 per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4102 | Oasis wound matrix | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4160 | Nushield 1 square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4161 | Bio-connekt per square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4162 | Wndex flw bioskn flw 0.5cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4163 | Woundex bioskin per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|-----------------------------|--|---|---|---|
| Q4164 | Helicoll per square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4165 | Keramatrix Kerasorb sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4166 | Cytal per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4167 | Truskin per sq centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4105 | Integra drt or omnigraft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |
| Q4169 | Artacent wound per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4170 | Cygnus per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4171 | Interfyl 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4173 | Palingen or palingen xplus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4174 | Palingen or promatrx | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4175 | Miroderm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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| Q4176 | Neopatch or therion per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4177 | Floweramnioflo 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4178 | Floweramniopatch per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4179 | Flowerderm per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4180 | Revita per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4181 | Amnio wound per square cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4182 | Transcyte per sq centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4183 | Surgigraft 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4184 | Cellesta or duo per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4185 | Cellesta flowab amnion 0.5cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4106 | Dermagraft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | – | – | – |

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| Q4107 | Graftjacket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4188 | Amnioarmor 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4189 | Artacent ac 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4190 | Artacent ac 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4191 | Restorigin 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4192 | Restorigin 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4193 | Coll-e-derm 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4194 | Novachor 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4195 | Puraply 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4196 | Puraply am 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4197 | Puraply xt 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |

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| Q4198 | Genesis amnio membrane 1sqcm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4199 | Cygnus matrix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4200 | Skin te 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4201 | Matrion 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4202 | Keroxx (2.5g/cc) 1cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4203 | Derma-gide 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4204 | Xwrap 1 sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4205 | Membrane graft or wrap sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| 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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4208 | Novafix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4209 | Surgraft per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| Q4210 | Axolotl graf dualgraf sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4211 | Amnion bio or axobio sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4212 | Allogen per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4213 | Ascent 0.5 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4214 | Cellesta cord per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4215 | Axolotl ambient cryo 0.1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4216 | Artacent cord per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4217 | Woundfix biowound plus xplus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4218 | Surgicord per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4219 | Surgigraft dual per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4220 | Bellacell HD Surederm sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| Q4221 | Amniowrap2 per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4222 | Progenamatrix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4224 | Hhf10-p per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4225 | Amniobind per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4227 | Amniocore per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (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, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4230 | Cogenex flow amnion 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4231 | Corplex p per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4232 | Corplex per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4233 | Surfactor /nudyn per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4234 | Xcellerate per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| Q4235 | Amniorepair or altiply sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4236 | Carepatch per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4237 | Cryo-cord per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4238 | Derm-maxx per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4239 | Amnio-maxx or lite per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4240 | Corecyte topical only 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4241 | Polycyte topical only 0.5cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4242 | Amniocyte plus per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4244 | Procenta per 200 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4245 | Amniotext per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4246 | Coretext or protext per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|---|---|---|
| Q4247 | Amniotext patch per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4248 | Dermacyte amn mem allo sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4249 | Amniplly per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4250 | Amnioamp-mp per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4251 | Vim per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4252 | Vendaje per square centimet | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4253 | Zenith amniotic membrane psc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4254 | Novafix dl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4255 | Reguard topical use per sq | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4256 | Mlg complet per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |
| Q4257 | Relese per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | – | – | – |

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|-------|------------------------------|--|----------|---|---|
| Q4258 | Enverse per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4259 | Celera per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4260 | Signature apatch per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4261 | Tag per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| Q4262 | Dual layer impax per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| Q4263 | Surgraft tl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| Q4264 | Cocoon membrane per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | - | - |
| Q4265 | Neostim tl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4108 | Integra matrix | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4266 | Neostim per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4114 | Integra flowable wound matri | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| Q4267 | Neostim dl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4116 | Alloderm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4268 | Surgraft ft per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4122 | Dermacell awm porous sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4269 | Surgraft xt per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4128 | Flexhd/allopachhd/sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4270 | Complete sl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4132 | Grafix core grafixpl core | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4271 | Complete ft per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | - | - |
| Q4133 | Grafix stravix prime pl sqcm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q5009 | Hospice care NOS | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|----------------------------|---|---|---|---|
| Q5103 | Injection inflectra | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q5104 | Injection renflexis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q5106 | Inj retacrit non-esrd use | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q5109 | Injection ixifi 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| Q4151 | Amnioband guardian 1 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4154 | Biovance 1 square cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S0117 | Tretinoin topical 5 g | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S0142 | Colistimethate inh sol mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S0157 | Becaplermin gel 1% 0.5 gm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| S0197 | Prenatal vitamins 30 day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S0310 | Hospitalist Visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S0320 | RN telephone calls to DMP | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S0590 | Misc integral lens serv | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| S0622 | Phys exam for college | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| Q4159 | Affinity1 square cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S0810 | Photorefractive keratectomy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S1001 | Deluxe item | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S1002 | Custom item | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q4168 | Amnioband 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4186 | Epifix 1 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| Q4187 | Epicord 1 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S2117 | Arthroereisis subtalar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S2120 | Low Density Lipoprotein(Ldl) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Prior Authorization may be required per contract agreement. | - | - | - |
| S2300 | Arthroscopy shoulder surgi | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S2409 | Fetal surg noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| Q5124 | Inj. byooviz 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|--|----------|---|---|
| Q5128 | Inj cimerli 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2023 | - | - |
| S3600 | Stat lab | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S3601 | Stat lab home/nf | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S3650 | Saliva test hormone level; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S3652 | Saliva test hormone level; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S3900 | Surface EMG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S4015 | Complete IVF nos case rate | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S0013 | Esketamine nasal spray | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S0800 | Laser in situ keratomileusis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S1091 | Stent non-coronary propel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S2083 | Adjustment gastric band | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S2112 | Knee arthroscop harv | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|-------------------------------|---|---|---|---|
| S2118 | Total hip resurfacing | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S2140 | Cord blood harvesting | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S4990 | Nicotine patch legend | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S4991 | Nicotine patch nonlegend | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S4995 | Smoking cessation gum | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5035 | Hit Routine Device Maint | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5036 | Hit Device Repair | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5100 | Adult daycare services 15min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5101 | Adult day care per half day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5102 | Adult day care per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5105 | Centerbased day care per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5108 | Homecare train pt 15 min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5109 | Homecare train pt session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5110 | Family homecare training 15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5111 | Family homecare train/session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5115 | Nonfamily homecare train/15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5116 | Nonfamily HC train/session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5120 | Chore services per 15 min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5121 | Chore services per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5125 | Attendant care service /15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5126 | Attendant care service /diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| S5130 | Homaker service nos per 15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S5131 | Homemaker service nos /diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S5135 | Adult companioncare per 15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5136 | Adult companioncare per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5140 | Adult foster care per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5141 | Adult foster care per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5145 | Child fostercare th per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5146 | Ther fostercare child /month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5150 | Unskilled respite care /15m | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5151 | Unskilled respitecare /diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5160 | Emer response sys instal&tst | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5161 | Emer rspns sys serv permonth | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5162 | Emer rspns system purchase | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5165 | Home modifications per serv | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5170 | Homedelivered prepared meal | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5175 | Laundry serv ext prof /order | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S5181 | HH respiratory thrpy nos/day | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S5185 | Med reminder serv per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|---|---|---|---|---|
| S5199 | Personal care item nos each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S5497 | HIT cath care noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S2142 | Cord blood-derived stem-cell | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8130 | INTERFERENTIAL CURRENT STIMULATOR 2 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S8131 | INTERFERENTIAL CURRENT STIMULATOR 4 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S8189 | Trach supply noc | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S8270 | Enuresis alarm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S8301 | Infect control supplies NOS | Unlisted: Procedure/service not specifically defined or classified, 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. | - | - | - |
| S2150 | BMT harv/transpl 28d pkg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8940 | Hippotherapy per session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S2202 | Echosclerotherapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8990 | Pt or manip for maint | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| S9001 | Home uterine monitor with or | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S9056 | Coma stimulation per diem | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S9090 | Vertebral axial decompressio | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | - | - | - |
| S2230 | Implant semi-imp hear | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9125 | Respite care in the home p | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S2235 | Implant auditory brain imp | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9379 | HIT noc per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S9381 | HIT high risk/escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9436 | Lamaze class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9437 | Childbirth refresher class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9438 | Cesarean birth class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9439 | VBAC class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9442 | Birthing class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9444 | Parenting class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9445 | PT education noc individ | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|--|---|---|---|---|
| S9446 | PT education noc group | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 review. | - | - | - |
| S9451 | Exercise class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9454 | Stress mgmt class | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S2411 | Fetoscop laser ther TTTS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9482 | Family stabilization 15 min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9542 | HT inj noc per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S2900 | Surgical Techniques Requiring Use Of Robotic Surgical System (List Separately In Addition To Code For Primary Procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S4023 | Incompl donor egg case rate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 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. | - | - | - |
| S9970 | Health club membership yr | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9975 | Transplant Related Per Diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9976 | Lodging per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| S9977 | Meals per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical 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 review. | - | - | - |
| S9986 | Not medically necessary svc | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9988 | Serv part of phase I trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9990 | Services provided as part of | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S9991 | Services provided as 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 review. | - | - | - |
| S9999 | Sales tax | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| T1014 | Telehealth transmit per min | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 contract/clinical review. | - | - | - |
| T2014 | Habil prevoc waiver per d | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2015 | Habil prevoc waiver per hr | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| T2016 | Habil res waiver per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2017 | Habil res waiver 15 min | Unlisted: Procedure/service not specifically defined or classified, maybe subject to 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 contract/clinical review. | - | - | - |
| T2024 | Serv asmnt/care plan waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2025 | Waiver service nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2026 | Special childcare waiver/d | Unlisted: Procedure/service not specifically defined or classified, maybe subject to 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 contract/clinical review. | - | - | - |
| T2030 | Assist living waiver/month | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2031 | Assist living waiver/diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2032 | Res care nos waiver/month | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |

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|-------|------------------------------|--|---|---|---|
| T2033 | Res nos waiver per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to 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 contract/clinical review. | - | - | - |
| T2038 | Comm trans waiver/service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2039 | Vehicle mod waiver/service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2040 | Financial mgt waiver/15min | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2041 | Support broker waiver/15 min | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| T2101 | Breast milk proc/store/dist | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| T5999 | Supply nos | Unlisted: Procedure/service not specifically defined or classified, 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 contract/clinical review. | - | - | - |
| V2599 | Contact lens/es other type | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| V2629 | Prosthetic eye other type | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| V2702 | Deluxe lens feature | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |

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|-------|-----------------------------|---|---|---|---|
| V2744 | Tint photochromatic lens/es | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | - | - | - |
| S4025 | Donor serv IVF case rate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S4026 | Procure donor sperm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| V2799 | Misc vision item or service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. Unlisted or Undefined: Procedures/services not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| V5090 | Hearing aid dispensing fee | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. | - | - | - |
| S4027 | Store prev froz embryos | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 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. | - | - | - |
| S4030 | Sperm procure init visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S4031 | Sperm procure subs visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|---|---|---|
| S4040 | Monit store cryo embryo 30 d | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8035 | Magnetic source imaging | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8930 | Auricular electrostimulation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S8948 | Low-level laser trmt 15 min | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9117 | Back school visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9335 | HT hemodialysis diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9472 | Cardiac rehabilitation progr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9558 | HT inj growth horm diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| S9562 | HT inj palivizumab diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| V2787 | Astigmatism-correct function | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| V2788 | Presbyopia-correct function | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |

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|-------|------------------------------|---|-----------|------------|---|
| V5095 | Implant mid ear hearing pros | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| V5362 | Speech Screening | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| V5363 | Language Screening | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | - | - | - |
| 64555 | IMPLANT NEUROELECTRODES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| 64575 | OPN IMPLTJ NEA PERPH NERVE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| 64590 | INSRT/REDO PN/GASTR STIMUL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| C1820 | Generator neuro rechg bat sy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| C1822 | Gen neuro hf rechg bat | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| J1726 | Makena 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/15/2023 | 12/31/2999 | - |
| J1729 | Inj hydroxyprogst capoat nos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/15/2023 | 12/31/2999 | - |
| K1024 | Non pneum comp control cal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 | - |
| K1025 | Non pneum compress full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 | - |

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|-------|------------------------------|---|-----------|------------|---|
| K1031 | Non pneu comp control w/o ca | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 | - |
| K1032 | Non pneum seq comp full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 | - |
| K1033 | Non pneum seq comp half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 | - |
| L8678 | Ext sply implt neurostim | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8679 | Imp neurosti pls gn any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8680 | Implt neurostim elctr each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8681 | Pt prgrm for implt neurostim | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8682 | Implt neurostim radiofq rec | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8683 | Radiofq trsmtr for implt neu | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8685 | Implt nrostm pls gen sng rec | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8686 | Implt nrostm pls gen sng non | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |

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|-------|------------------------------|--|-----------|------------|---|
| L8687 | Implt nrostm pls gen dua rec | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8688 | Implt nrostm pls gen dua non | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8689 | External recharg sys intern | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| L8695 | External recharg sys extern | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 | - |
| J9029 | Inj adstiladrin per tx dos | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 | - |
| J9381 | Inj teplizumab mzwv 5 mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 | - |
| J1576 | Inj panzyga 500 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 | - |
| J2329 | Inj ublituximab-xiiy 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |
| C9786 | Echo cad for hf preserved ef | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 | - |
| Q4284 | Dermabind sl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4283 | Biovance tri or 3l sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |

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|-------|------------------------------|--|-----------|------------|---|
| Q4282 | Cygnus dual per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4281 | Barrera slor dl per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4280 | Xcell amnio matrix per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4278 | Epieffect per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4277 | Woundplus e-grat per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4276 | Orion per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4275 | Esano aca per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4274 | Esano ac per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4273 | Esano aaa per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| Q4272 | Esano a per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| J3396 | Verteporfin injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |

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|-------|-----------------------------|--|-----------|------------|---|
| J0179 | Inj brolucizumab-dbll 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |
| J0178 | Aflibercept injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |
| C9785 | Endo outlet restrict w/tube | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| C9784 | Endo sleeve gastro w/tube | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| 90880 | HYPNOTHERAPY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 | - |
| 67027 | IMPLANT EYE DRUG SYSTEM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 | - |
| 0809T | ARTHRD SI JT PRQ TFX&IMPLT | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 | - |
| 0545T | TCAT TV ANNULUS RCNSTJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 | - |
| 0569T | TTVR PERQ APPR 1ST PROSTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 | - |
| 0570T | TTVR PERQ EA ADDL PROSTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 | - |

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|-------|---|---|------------|------------|--------------------------|
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| 0600T | IRE ABLTJ 1+TUM ORGAN PERQ | | 9/1/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| 0601T | IRE ABLTJ 1+TUMORS OPEN | | 9/1/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| 0740T | REM AUTON ALG NSLN CAL SETUP | | 9/1/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| 0741T | REM AUTON ALG NSLN DATA COLL | | 9/1/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| 98978 | REM THER MNTR DEV SPLY CBT | | 9/1/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| A4341 | Iduc valve pat inst repl | | 11/15/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| A4342 | Iduc valve sply repl | | 11/15/2023 | 12/31/2999 | |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| J7183 | INJECTION VON WILLEBRAND FACTOR COMPLEX (HUMAN) WILATE 1 I.U. VWF:RCO | | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| | | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | | | - |
| J3111 | Inj. romosozumab-aqqg 1 mg | | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |

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|-------|------------------------------|---|------------|------------|--------------------------|
| J2796 | Romiplostim injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| J2354 | Octreotide inj non-depot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| J2353 | Octreotide injection depot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| J1930 | Lanreotide injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| J0485 | Belatacept injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 | Add effective 03/01/2024 |
| 0597T | TEMP FML IU VALVE-PMP RPLCMT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 | - |
| 0596T | TEMP FML IU VLV-PMP 1ST INSJ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 | - |
| 59072 | UMBILICAL CORD OCCLUD W/US | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| 59076 | FETAL SHUNT PLACEMENT W/US | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2400 | Fetal surg congen hernia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2401 | Fetal surg urin trac obstr | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2402 | Fetal surg cong cyst malf | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2403 | Fetal surg pulmon sequest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |

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| S2404 | Fetal surg myelomeningo | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2405 | Fetal surg sacrococ teratoma | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| S2409 | Fetal surg noc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| L5991 | Add to lower ext prostheses, osseointegrated ext prost connector | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| E0490 | Power source/control electronics unit for oral device/appliance for neuro musc elec stim tongue muscle | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| E0491 | Oral device/appliance for neuro musc elec stim tongue muscle, 90-day supply | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| K1036 | Supplies/accessories low freq ultrasonic diathermy per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| Q4285 | Nudyn dl or nudyn dl mesh, per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| Q4286 | Nudyn sl or nudyn slw, per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| A2022 | Innovaburn or innovamatrix xl, per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |

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|-------|------------------------------|--|------------|------------|---|
| A2023 | Innovamatrix pd, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| A2024 | Resolve matrix, per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| A2025 | Miro3d, per cubic cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 | - |
| A4560 | Nmes disposable | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | 12/31/2999 | Add effective 1/15/2024 |
| C9157 | Injection, tofersen, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| A4560 | Nmes disposable | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 1/14/2024 | Add effective 10/15/2023 Retire effective 01/14/2024 |
| 95982 | IO GA N-STIM SUBSQ W/REPROG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| J0174 | Inj lecanemab-irmb 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2023 | 12/31/2999 | - |
| K1017 | Monthly supp use with k1016 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |
| K1016 | Trans elec nerv for trigemin | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |
| J0741 | Inj cabote rilpivir 2mg 3mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |

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|-------|------------------------------|--|------------|------------|---|
| J0739 | Injection cabotegravir 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |
| 0322U | NEURO ASD MEAS 14 ACYL CARN | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 2/1/2024 | Add effective 10/15/2023 Retire effective 02/01/2024 |
| 0322U | NEURO ASD MEAS 14 ACYL CARN | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 2/1/2024 | 12/31/2999 | Add effective 02/01/2024 |
| 95981 | IO ANAL GAST N-STIM SUBSQ | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 | - |
| E0746 | Electromyograph biofeedback | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 | - |
| 93264 | REM MNTR WRLS P-ART PRS SNR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |
| 33289 | TCAT IMPL WRLS P-ART PRS SNR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 | - |
| 0422T | TACTILE BREAST IMG UNI/BI | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 | - |
| 0332T | HEART SYMP IMAGE PLNR SPECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 | - |
| 0072T | US LEIOMYOMATA ABLATE >200 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | - |

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|-------|-----------------------------|---|-----------|------------|-------------------------|
| 0071T | US LEIOMYOMATA ABLATE <200 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | - |
| C9734 | U/S trtmt not leiomyomata | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | - |
| 64624 | DSTRJ NULYT AGT GNCLR NRV | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | Add effective 12/1/2023 |
| 0072T | FCSD US ABLTJ LEIOMYOM>=200 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | Add effective 12/1/2023 |
| 0071T | US LEIOMYOMATA ABLATE <200 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 | Add effective 12/1/2023 |

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Please note that checking eligibility and benefits and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of New Mexico (BCBSNM). For other services/members, BCBSNM has contracted with Carelon Medical Benefits Management for utilization management and related services.

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